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District IX health plan

TRICT IX HEALTH PLAN

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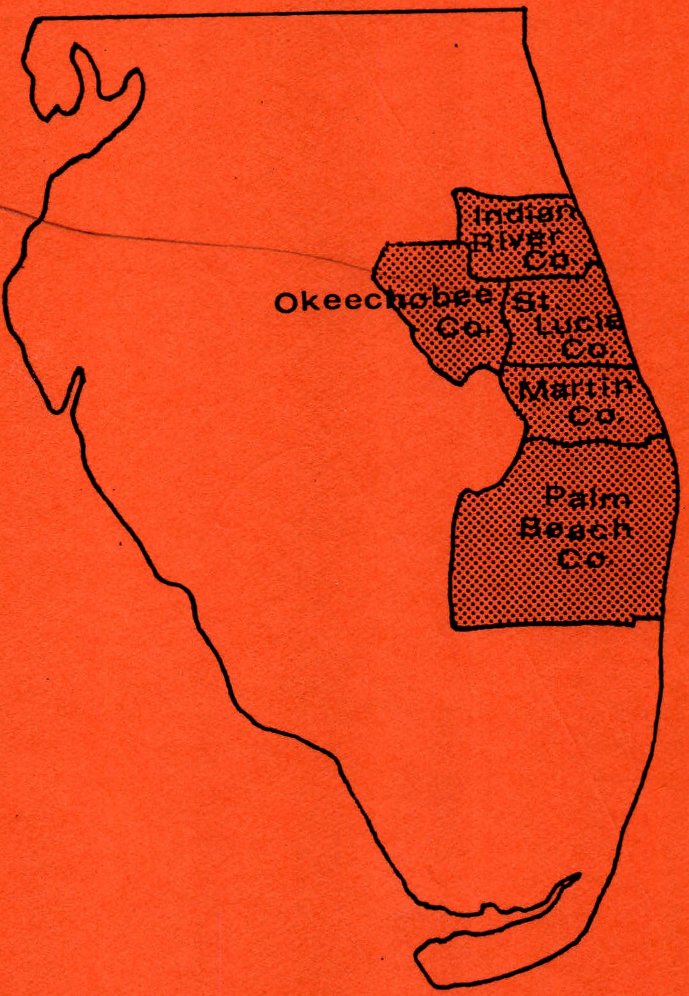

DISTRICT IX HEALTH COUNCIL, INC.
Serving Indian River, Martin, Okeechobee, Palm Beach & St. Lucie Counties
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West Palm Beach, Fl. 33407
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DISTRICT IX HEALTH COUNCIL, INC.
1984
HEALTH PLAN

Components

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Dental Health	First Green Cover
Emergency Medical Servcies	Second Green Cover
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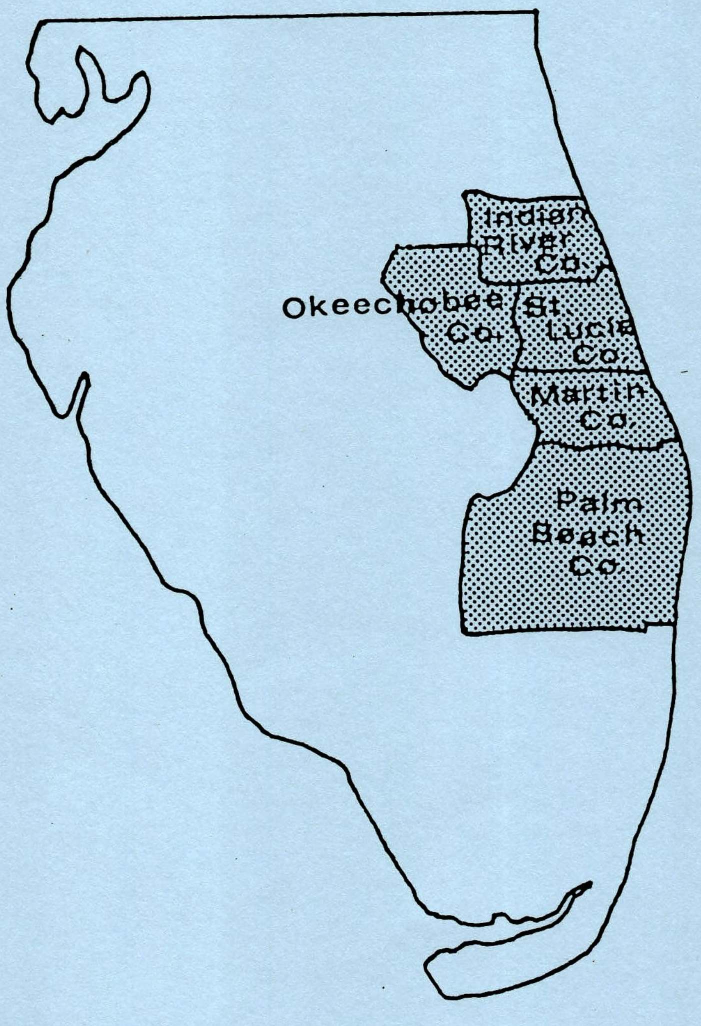
Acute Care	Second Gold Cover
Psychiatric and Substance Abuse	Third Gold Cover

Adopted by the Board of Directors of
DISTRICT IX HEALTH COUNCIL, INC.
June 28, 1984

DISTRICT IX HEALTH PLAN

1984



INTRODUCTION

INTRODUCTION

The National Health Planning and Resources Development Act of 1974 (Public Law 93-64) designated Health Systems Agencies (HSAs) as the organizational units responsible for improved health planning at the local level. The Health Planning Council, Inc., originally chartered in February, 1968 pursuant to Public Law 89-749, became the HSA for the Counties of Indian River, Martin, Okeechobee, Palm Beach, and St. Lucie. On October 1, 1982, the Federal Health Planning Law, with respect to local planning, was phased out in Florida.

Sections 2 and 3, Chapter 82-182, Laws of Florida were signed into law by the Governor on April 21, 1982 and provided for the establishment of eleven local health councils and the establishment of a Statewide Health Council. Based on this authorizing Statute, the District IX Health Council, Inc. was incorporated on November 3, 1982 and became operational on January 1, 1983.

The local council members are appointed by the County Commissions having jurisdiction in the particular service district. The District IX Health Council consists of twelve Board members who serve two year terms. The Board members are representatives of health care providers, health care purchasers, and non-governmental health care consumers. The Council is supported by three staff members: an executive director, a health planner and an administrative assistant.

The functions of the local health councils differ from the predecessor HSAs in that they emphasize the advocacy of preventive health care and local health care planning. Furthermore, the local health councils are required to submit to the Department of Health and Rehabilitative Services a yearly local health plan. As defined in Florida Statutes, the local health councils shall:

> *"Develop a district plan, using uniform methodology as set forth by the Department (HRS) which will permit each local health council to develop goals and criteria based upon its unique local health needs, such as the special health needs of rural areas and medically underserved communities.*
>
> *"The district plan shall be submitted to the Department and updated periodically and shall be in a form prescribed by the Department. The elements of an approved district plan which are necessary to the review of any certificate-of-need application shall be adopted by the Department as a part of its rules."*

The Department of HRS is required to make its Certificate of Need determinations in the context of the local health plan as well as statutorily mandated criteria. In this way, the local councils continue to give input into the CON decision-making process through the local plan, but eliminate the statutory requirement of local review of CON applications.

The Council is also a clearing house for information. It acquires, assembles, and analyzes data concerning the status of the health of area residents and of the health delivery system. The Council keeps track of the number, type, and location of health resources and the corresponding patterns of utilization. It collects information yearly from area nursing homes and monthly from the hospital sector. The Council provides technical assistance to CON applicants, to coordinating agencies (such as the Area Agency on Aging), and to members of the public who need information.

This Council continues to carry out programs that were initiated by our predecessor organization, the Health Planning Council, Inc., by the adoption of all major plans and documents produced by that Council. Therefore, the District IX Health Council, Inc. has at its disposal a wealth of information and program guidance that covers a broad spectrum of Health Programs.

Policies and Assumptions

> *(For specific recommendations within the areas of acute care, psychiatric and substance abuse, long term care, emergency medical services and dental health, please refer to the individual components within this Plan.)*

*Many of the major chronic diseases in America are preventable. Indeed, many are preventable by actions well within the control of each individual. Personal lifestyles are responsible for a large share of unnecessary disease and disability in the United States. Each individual clearly needs to make a greater effort to reduce his risk of incurring avoidable diseases and injuries. Personal health and well being is the responsibility of the individual. In the United States, we have developed a reliance on medical care providers almost to the exclusion of personal responsibility. Health is not the treatment of disease, but rather the positive well being that is the result of a satisfactory relationship between man, his heredity, his lifestyle, and the environment (a symbiotic, holistic interaction). Health is not primarily related to the quantity and quality of medical care, but to genetic, environmental, and personal behavior. Positive health can be achieved only through the intelligent efforts on the part of each individual.**

The individual also has a responsibility in bringing about changes which are necessary to reduce or eliminate environmental hazards to health. Working as a concerned citizen, the individual can apply pressure at key points in the system to reduce air and water pollution, substandard housing, solid waste problems, and traffic hazards.

The organization of the health delivery system and the interrelationship of its components are also amenable to change. Most of the problems that people have regarding medical care can be alleviated by addressing the system characteristics of accessibility, availability, acceptability, continuity, cost, and quality. From an economic standpoint, resources are scarce in relation to human wants, resources have alternative uses, and there is significant variation in the importance people attach to different wants.

The District IX Health Council, acting as a representative of the community, expresses the beliefs and values of the community regarding (a) the individual's own responsibility for health, (b) the organization of the health delivery system, (c) the interrelationship between system components, and (d) the interaction between the health system and other community systems. These beliefs and values are expressed as policies and assumptions and are as follows:

Health Delivery System

> *-The health delivery system should function in a way that allows each individual to receive the physical or mental health services needed when they are necessary, in a manner which maintains dignity, and at a cost which*

**Fuchs, Victor R., Who Shall Live, Basic Books, Inc., 1974, Pg. 28.*

is affordable to the individual or to society.

-The health delivery system should provide comprehensive, high quality physical or mental health services in a manner which assures continuity of care in a healthful environment.

-The health delivery system should promote activities for the prevention of diseases, including studies of nutritional and environmental factors affecting health and the provision of preventive health services.

-The health delivery system should promote activities which explore different organizational structures for the provision of health care including the development of medical group practices and health maintenance organizations.

-The health delivery system should promote the development of institutions and services with the ability to provide primary, secondary, and tertiary health care on a geographically integrated basis.

-The health delivery system should promote effective energy conservation and fuel efficiency programs for health service institutions to reduce the demand for fossil fuels.

-The health delivery system should promote competitive forces in the health services industry whenever competition and consumer choices can constructively serve to advance the purposes of quality assurance, cost effectiveness, and access.

Interrelationships of System Components

-The components of the health delivery system should function in an effective, efficient, and economical way which would assure that each person receives the least costly physical or mental health services consistent with his or her needs.

-The components of the health delivery system should promote the development of multi-institutional systems for coordination or consolidation of institutional health services.

-The components of the health delivery system should promote the development of multi-institutional arrangements for the sharing of support services necessary to all health care institutions.

-The components of the health delivery system should promote the training and effective utilization of health manpower including the development of new skills and levels of competence.

-The components of the health delivery system should promote the adoption of uniform cost accounting, simplified reimbursement, utilization reports, and improved management procedures.

Interactions Between Community Systems

-The health delivery system should explore management concepts and techniques used successfully by other community systems (public and private)

to determine their applicability to the health system.

-The health delivery system should actively participate in the development and coordination of other community systems to assure orderly growth and management of the environment. Community systems include education, social services, transportation, land use, solid waste, water treatment, and construction; to name a few.

Individual Responsibilites for Health

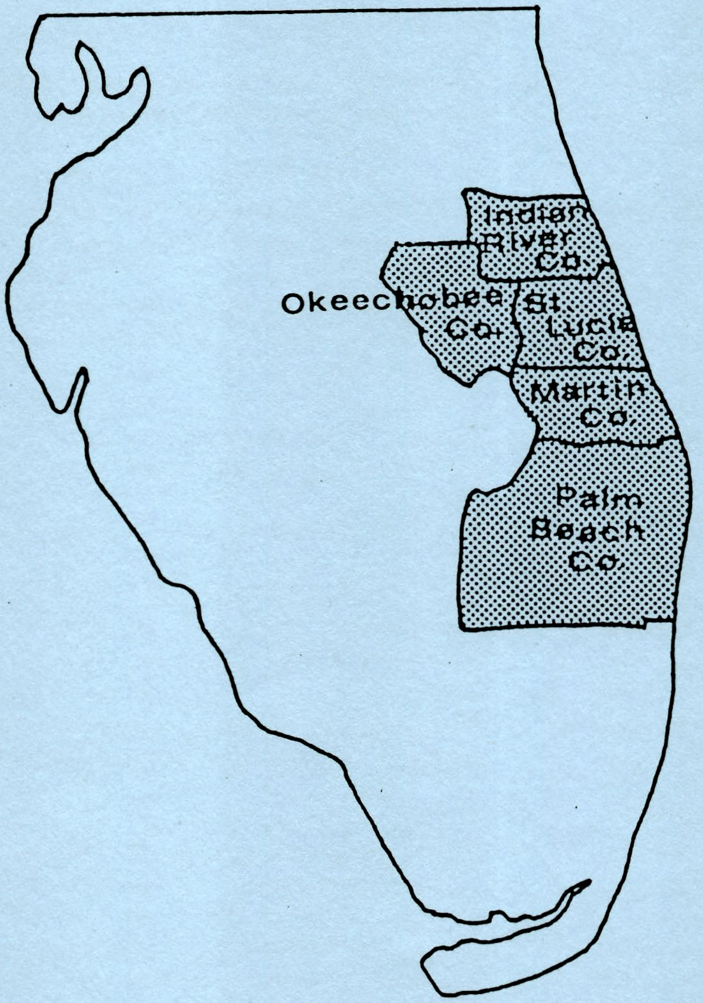
-The individual has a responsibility to become knowledgeable about and to practice healthful living habits which include acceptance of self responsibility, mental health, nutritional awareness, physical fitness, and environmental sensitivity.

-The individual has a responsibility to become knowledgeable about the health delivery system and to use the system in the most effective and least costly manner.

-The individual has a responsibility to become involved in the planning for and the development of community health programs.

DISTRICT IX HEALTH PLAN

1984



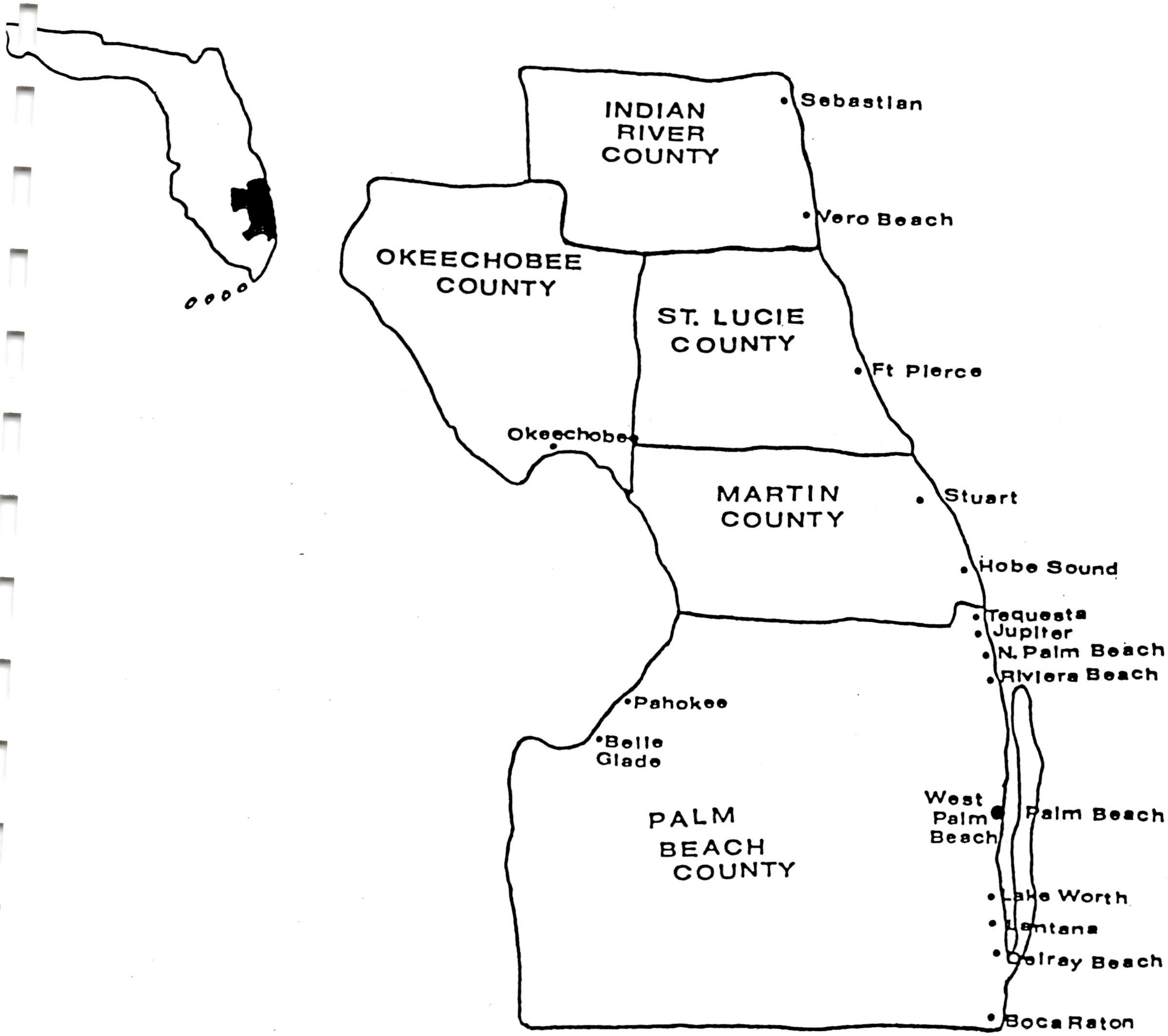
PROFILE

HEALTH PROFILE

INTRODUCTION

As the initial component of the District IX Health Plan, this section is intended to give an overview of the area's demographic and socioeconomic characteristics and the health status of its residents. In order to do comprehensive health planning, a solid understanding of the region is imperative. This Health Profile is intended to provide this foundation and all plan components will build upon it.

HRS - DISTRICT IX



DEMOGRAPHICS OF DISTRICT IX

POPULATION TRENDS

From 1970 to 1983, the population of District IX has grown almost 93% (from 478,996 persons in 1970 to an estimated 924,210 persons in 1983). In comparison, the State of Florida experienced a growth rate of almost 56% during the same thirteen year period (from 6,791,481 persons in 1970 to an estimated 10,591,701 persons in 1983). During the decade between the 1970 and 1980 Census, the District IX population grew slightly over 70% while the State as a whole grew just under 44%. Hence, it can be easily noted that this five county region is a rapidly growing area. District IX also has experienced a tremendous growth in residents 65 years of age and over. In 1970, approximately 17% of District IX's population was over 65 years of age and in 1980, the figure increased to 22.2%. For further information, please refer to the Long Term Care Section of this document.

Within the individual counties of District IX, Martin County experienced the largest percentage increase in population (117.6%) from 1970 to 1980 followed by Okeechobee (80.4%), St. Lucie (71.5%), Indian River (66.4%) and Palm Beach (63.4%). However, since the 1980 Census, St. Lucie County has shown the largest percentage increase (20.7%) followed by Indian River (15.9%), Martin (15.8%), Palm Beach (13.1%) and Okeechobee (12.8%).

For the entire District, the actual numbers of new residents point to tremendous growth in Palm Beach County and in St. Lucie County.

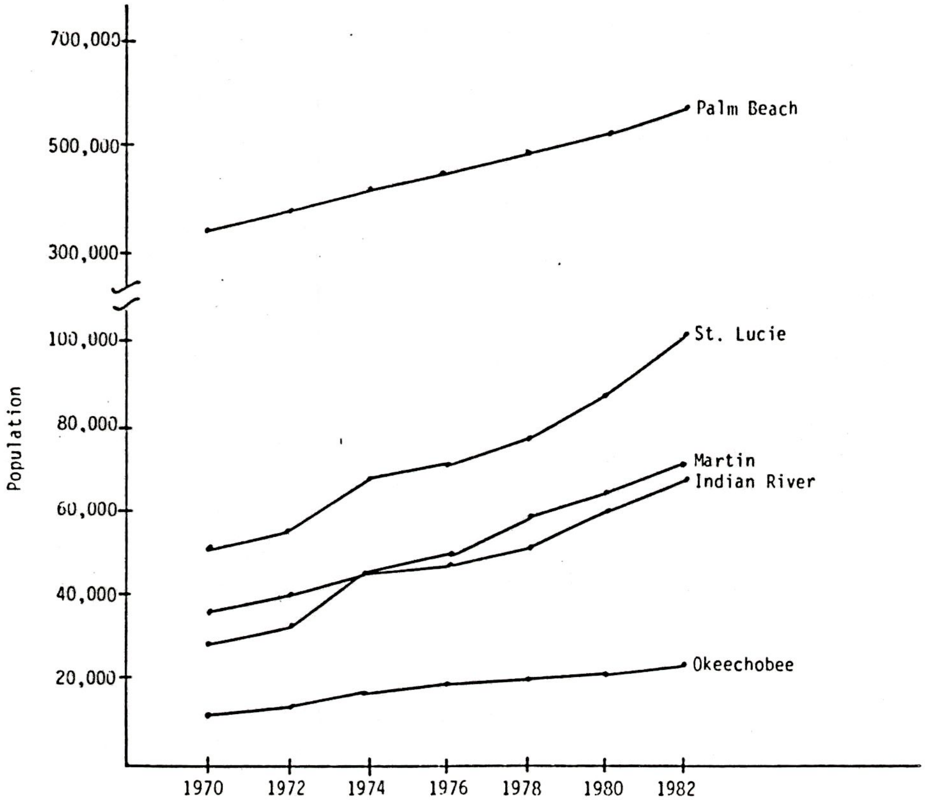
TABLE I - A

NUMBERS OF NEW RESIDENTS IN DISTRICT IX

County	1970--1980	1980--1983
Indian River	23,904	9,518
Martin	35,979	10,129
Okeechobee	9,031	2,603
Palm Beach	227,819	75,750
St. Lucie	36,346	18,042

Figure 1 shows each county's population increases and trends from 1970 to 1982. The vast majority of the poulation increase is due to in-migration. (See Table I-B) Okeechobee is the only county to show any significant degree of natural increase.

Figure 1: COUNTY POPULATION TRENDS
1970--1982



Source: University of Florida Population Studies

TABLE 1 - B

POPULATION INCREASE
1980 -- 1983

County	*1980**	*1983+*	*% Change 1980-1983*	*% of Change Due To*	
				Natural Increase	*Net Migration*
Indian River	*59,896*	*69,414*	*+15.9%*	*3.03*	*96.97*
Martin	*64,014*	*74,143*	*+15.8%*	*0.00*	*100.00*
Okeechobee	*20,264*	*22,867*	*+12.8%*	*26.70*	*73.30*
Palm Beach	*576,812*	*652,562*	*+13.1%*	*1.18*	*98.82*
St. Lucie	*87,182*	*105,224*	*+20.7%*	*9.00*	*91.00*

**HRS 1983 County Age Group Projections*
+Florida Estimates of Population, April 1, 1983

POPULATION BY AGE, SEX AND RACE

According to the 1980 Census, 17.2% of Florida's residents were aged 65 and over. Within District IX, a greater portion of the population is 65 and over (22.2%). Within counties, Martin County had the largest elderly population (24.5%), followed closely by Palm Beach (23.3%). Okeechobee had the smallest elderly population (12.1%). Age and sex components of the population are detailed in Table II.

In 1980, 15.7% of the population in District IX was non-white as compared to 20.3% in 1970. The racial composition of the five county area has consistently declined in the percentage of black and other races (non-white) from 20.3% in 1970 to 16.1% in 1980. This occurred despite an actual increase in the number of non-white residents. St. Lucie County had the largest non-white population in 1980 (23%) while Martin County had the smallest (9.6%). Palm Beach County had the largest percentage of residents of Spanish origin (4.9%) while the State of Florida as a whole, had 8.8% of its residents with Spanish origin.

TABLE II
PERMANENT RESIDENT POPULATION BY AGE AND SEX
APRIL 1, 1980

COUNTY	AGE	TOTAL	FEMALE	MALE
INDIAN RIVER	0-4	3,281	1,620	1,661
	5-9	3,467	1,690	1,777
	10-14	4,064	2,022	2,042
	15-19	4,742	2,182	2,560
	20-24	4,279	2,063	2,216
	25-34	7,451	3,655	3,796
	35-44	5,791	2,946	2,845
	45-54	6,123	3,266	2,857
	55-64	8,518	4,631	3,887
	65-74	8,079	4,281	3,798
	75+	4,101	2,311	1,790
	18+	46,159	23,971	22,188
	TOTAL	59,896	30,667	29,229
MARTIN	0-4	3,081	1,525	1,556
	5-9	3,503	1,699	1,804
	10-14	3,933	1,900	2,033
	15-19	4,649	2,207	2,442
	20-24	4,380	2,064	2,316
	25-34	7,671	3,761	3,910
	35-44	6,001	3,011	2,990
	45-54	5,905	3,060	2,845
	55-64	9,237	5,195	4,042
	65-74	10,329	5,480	4,849
	75+	5,325	2,838	2,487
	18+	50,805	26,304	24,501
	TOTAL	64,014	32,740	31,274
OKEECHOBEE	0-4	1,682	830	852
	5-9	1,645	772	873
	10-14	1,819	840	979
	15-19	2,026	828	1,198
	20-24	1,544	778	766
	25-34	2,722	1,407	1,315
	35-44	2,226	1,120	1,106
	45-54	2,037	1,010	1,027
	55-64	2,112	1,087	1,025
	65-74	1,743	855	888
	75+	708	367	341
	18+	13,729	6,931	6,798
	TOTAL	20,264	9,894	10,370
PALM BEACH	0-4	29,914	14,583	15,331
	5-9	32,340	15,800	16,540
	10-14	36,074	17,799	18,275
	15-19	40,549	20,039	20,510
	20-24	41,039	20,669	20,370
	25-34	78,789	39,153	39,636
	35-44	57,085	28,496	28,589
	45-54	53,863	28,485	25,378
	55-64	72,758	41,763	30,995
	65-74	86,697	48,193	38,504
	75+	47,755	26,892	20,863
	18+	453,780	241,559	212,221
	TOTAL	576,863	301,872	274,991
ST. LUCIE	0-4	6,082	2,940	3,412
	5-9	6,375	3,156	3,219
	10-14	6,389	3,122	3,267
	15-19	6,746	3,342	3,404
	20-24	6,808	3,552	3,256
	25-34	12,346	6,197	6,149
	35-44	8,473	4,198	4,275
	45-54	8,143	4,231	3,912
	55-64	11,023	6,097	4,926
	65-74	10,060	5,226	4,834
	75+	4,737	2,654	2,083
	18+	64,210	33,472	30,738
	TOTAL	87,182	44,715	42,467

Please Note: *As per PHC 80-3-11 Florida Change Sheet of January, 1983, the total for Palm Beach County should have been 576,812 instead of 576,863.*

PERMANENT RESIDENT POPULATION BY AGE AND SEX - - CONTINUED
APRIL 1, 1980

AREA	AGE	TOTAL	FEMALE	MALE
DISTRICT IX	0-4	44,040	21,498	22,542
	5-9	47,330	23,117	24,213
	10-14	52,279	25,683	26,596
	15-19	58,712	28,598	30,114
	20-24	58,050	29,126	28,924
	25-34	108,979	54,173	54,806
	35-44	79,576	39,771	39,805
	45-54	76,071	40,052	36,019
	55-64	103,648	58,773	44,875
	65-74	116,908	64,035	52,873
	75+	62,626	35,062	27,564
	18+	628,683	332,237	296,446
	TOTAL	808,219	419,888	388,331
FLORIDA	0-4	570,224	278,938	291,286
	5-9	621,534	304,280	317,254
	10-14	685,016	335,102	349,914
	15-19	811,340	399,882	411,458
	20-24	811,427	407,182	404,245
	25-34	1,411,411	714,867	696,544
	35-44	1,038,778	534,819	503,959
	45-54	989,160	518,994	470,166
	55-64	1,119,861	617,421	502,440
	65-74	1,059,153	588,700	470,453
	75+	628,420	370,513	257,907
	18+	7,386,688	3,915,992	3,470,696
	TOTAL	9,746,324	5,070,698	4,675,626

Source: Bureau of Economic and Business Research, Population Program, University of Florida, March, 1982

TABLE III

AGE DISTRIBUTION (IN PERCENTAGES) OF 1980 POPULATION

AREA	0-14	15-44	45-64	65+
Indian River	18.1%	37.2%	24.4%	20.3%
Martin	16.4%	35.5%	23.6%	24.5%
Okeechobee	25.4%	42.0%	20.5%	12.1%
Palm Beach	17.0%	37.7%	22.0%	23.3%
St. Lucie	21.6%	39.4%	22.0%	17.0%
District IX	17.8%	37.8%	22.2%	22.2%
Florida	19.3%	41.8%	21.6%	17.3%

Source: Florida Estimates of Population, 1982, pp.44-47.

TABLE *IV*

POPULATION-CENSUS COUNTS OF INHABITANTS BY RACE AND SPANISH ORIGIN--1980

AREA	RACE										Persons of Spanish Origin*	
	White		Black		American Indian & Eskimo		Asian & Pacific Islander		Other			
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Indian River	51,104	(85.3%)	7,806	(13.0%)	49	(0.1%)	154	(0.3%)	783	(1.3%)	1,382	(2.3%)
Martin	57,895	(90.4%)	4,719	(7.4%)	62	(0.1%)	195	(0.3%)	1,143	(1.8%)	2,084	(3.3%)
Okeechobee	17,926	(88.4%)	1,717	(8.5%)	79	(0.4%)	63	(0.3%)	479	(2.4%)	962	(4.7%)
Palm Beach	483,968	(84.4%)	77,440	(13.5%)	596	(0.1%)	2,128	(0.4%)	8,993	(1.6%)	28,274	(4.9%)
St. Lucie	67,159	(77.0%)	19,032	(21.8%)	138	(0.2%)	316	(0.4%)	537	(0.6%)	1,742	(2.0%)
District IX	678,052	(84.3%)	110,714	(13.8%)	924	(0.1%)	2,856	(0.4%)	11,935	(1.5%)	34,444	(4.3%)
Florida	8,178,387	(83.9%)	1,342,478	(13.8%)	19,316	(0.2%)	56,756	(0.6%)	143,055	(1.5%)	857,898	(8.8%)

*These percentages are based on the total population by county.
Source: 1981 Florida Statistical Abstract, pp. 19 and 20.

POPULATION DENSITY

There is a wide variation in population density among the counties in District IX due to the mixture of urban and rural areas. At one extreme, Palm Beach County had 327 persons per square mile in 1983 while the State, as a whole, had 196 persons per square mile. This fact makes Palm Beach the tenth most densely populated county. On the other hand, Okeechobee County had 30 persons per square mile in 1983 (ranked No. 48 in the State).

TABLE V
POPULATION DENSITY: PERSONS PER SQUARE MILE AND RANK ACCORDING TO DENSITY IN THE STATE
1960, 1970, 1980, and 1983

AREA	Land Area (Sq. Mi.)	Persons Per Sq. Mi. 1960	1970	1980	1983	Density Rank Among Cos. 1960	1970	1980	1983
Indian River	497	50	72	121	140	23	24	21	21
Martin	555	31	51	115	134	32	27	23	22
Okeechobee	771	8	15	26	30	61	54	48	48
Palm Beach	1,993	113	175	289	327	11	11	10	10
St. Lucie	581	68	87	150	181	20	21	19	18
Florida	54,153	92	125	180	196	X	X	X	X

Source: 1983 Florida Estimates of Population P. 42-43.

SOCIO-ECONOMIC CHARACTERISTICS IN DISTRICT IX

ECONOMIC STATUS

In 1980, Palm Beach County had the highest per capita income in the State of Florida. Moreover, three out of five counties were in the top ten (Indian River was ranked #5 and Martin was ranked #6). Okeechobee County had the lowest per capita income and was ranked 46th in the State. The State, as a whole, was below the national average as were St. Lucie and Okeechobee Counties. (See Table VI)

Table VII shows the per capita income by county for the years 1975 through 1980. Palm Beach and Martin Counties had the largest percent increase (77.2% and 76.6%, respectively). All five counties displayed larger increases than the State. Table VIII specifies these increases by type from 1975 to 1980.

TABLE VI-a
PER CAPITA INCOME -- 1980

Area	Rank in State	% of U.S. Average
Indian River	5	104%
Martin	6	103%
Okeechobee	46	64%
Palm Beach	1	121%
St. Lucie	21	83%
Florida	XX	95%

Source: 1982 Florida Statistical Abstract, pp. 153.

TABLE VI-b
POVERTY STATUS -- 1980

Area	Population Below Poverty Level	Percentage
Indian River	7,192	12.2%
Martin	6,938	11.1%
Okeechobee	3,473	17.5%
Palm Beach	57,247	10.1%
St. Lucie	14,768	17.1%

Source: University of Florida Bureau of Economic and Business Research

TABLE *VII*
PERSONAL INCOME: PER CAPITA AMOUNTS
ON A PLACE OF RESIDENCE BASIS
(ROUNDED TO DOLLARS)

AREA	1975	1976	1977	1978	1979	1980	1975-80 Per Cent Change
Indian River	5777	6444	7184	8021	8864	9917	71.7%
Martin	5557	6045	6736	7474	8438	9812	76.6%
Okeechobee	3528	3733	4109	4571	5278	6097	72.8%
Palm Beach	6520	7093	7991	8973	10172	11554	77.2%
St. Lucie	4543	4905	5400	5973	6893	7888	73.6%
Florida	5530	5918	6510	7212	8034	8993	62.6%

Source: 1982 Florida Statistical Abstract, pp. 151 and 152.

TABLE *VIII*
PERSONAL INCOME: PERCENTAGE INCREASES
IN SPECIFIED ITEMS FROM 1975--1980

	PERSONAL INCOME BY PLACE OF WORK		PERSONAL INCOME BY PLACE OF RESIDENCE				
AREA	TOTAL	WAGE & SALARY DISBURSEMENTS	TOTAL	PER CAPITA	DIVIDEND INTEREST & RENT	TRANSFER PAYMENTS	POPULATION INCREASE
Indian River	92.6%	89.0%	118.1%	71.7%	142.2%	112.6%	26.8%
Martin	159.1%	163.6%	133.1%	76.6%	140.4%	111.8%	32.1%
Okeechobee	91.1%	95.5%	104.5%	72.8%	125.9%	106.9%	18.0%
Palm Beach	111.6%	109.9%	115.1%	77.2%	124.2%	96.0%	21.4%
St. Lucie	130.7%	130.5%	119.4%	73.6%	118.4%	103.3%	26.3%
Florida	85.5%	82.3%	87.7%	62.6%	98.9%	84.8%	15.5%

Source: 1982 Florida Statistical Abstract, pp, 178-179.

UNEMPLOYMENT

Martin County has traditionally had the lowest unemployment rate in District IX and St. Lucie County has had the highest rate. All five counties have seen increases in unemployment from 1979 to 1982. Indian River, Okeechobee and St. Lucie Counties consistently have unemployment rates higher than the State average.

TABLE IX
UNEMPLOYMENT RATES

AREA	*1979*	*1980*	*1981*	*1982*
Indian River	*9.1*	*10.1*	*10.7*	*12.4*
Martin	*4.8*	*4.3*	*5.7*	*7.2*
Okeechobee	*7.9*	*8.1*	*11.2*	*12.7*
Palm Beach	*6.5*	*5.9*	*6.8*	*7.8*
St. Lucie	*10.5*	*10.6*	*13.6*	*15.4*
Florida	*6.0*	*5.9*	*6.8*	*8.2*

Source: 1982 Florida Statistical Abstract, pp. 194-196; Florida State Employment Service.

OCCUPATIONAL MIX

Clerical workers comprised the largest portion of the work force in 1980 (20.8%), followed closely by service workers (19.4%). Both categories are expected to continue growing in the eighties. Professional and technical occupations are predicted to increase dramatically (82%) during the next ten years, as well. Overall, all occupations are projected to increase 74% by 1990.

TABLE X
OCCUPATIONAL EMPLOYMENT: ESTIMATES (1980) AND PROJECTIONS (1990) OF EMPLOYMENT BY MAJOR OCCUPATIONAL CATEGORY

DISTRICT IX	Estimated 1980 No.	%	Projected 1990	% Change 1980-1990
All Occupations	184,852	(100.0%)	321,382	74%
Clerical Workers	38,432	(20.8%)	68,526	78%
Service Workers	35,966	(19.4%)	68,470	90%
Professional, Technical & kindred Workers	26,565	(14.4%)	48,348	82%
Crafts & Kindred Workers	23,446	(12.7%)	36,638	56%
Managers & Officials	17,480	(9.5%)	29,849	71%
Operatives	15,508	(8.4%)	25,940	67%
Sales Workers	13,837	(7.5%)	22,083	60%
Laborers, Except Farm	13,619	(7.3%)	21,528	58%

Source: 1982 Florida Statistical Abstract, p. 205

FARMING

*While farms in District IX account for only 5% of the total number of farms in Florida, almost one-quarter (25%) of the value of all farm products sold are from District IX. Okeechobee County has the greatest percentage of total land area utilized by farm land (81%). All five counties have over 50% of the land area occupied by farms. In comparison, only 38% of the State of Florida is farmland with an average product value per farm of $69,148. Palm Beach County farms averaged a $684,745 value per farm, followed by Martin ($295,816 per farm). This sizeable volume of farming accounts for the large migrant and seasonal farm worker population in the District (57,207 persons).**

TABLE *XI*
FARMS
NUMBER AND VALUE OF PRODUCTS SOLD--1978

	Number of Farms			Land in Farms		Value of Products Sold	
		Sales of Over $2500					
AREA	Total	Number	Percent	Acres	Percent of Total Land Area	Total (in $1000)	Per Farm (Dollars)
Indian River	451	357	79.2%	176,659	54.6%	43,119	95,607
Martin	220	172	78.2%	206,804	58.1%	65,079	295,816
Okeechobee	289	227	78.5%	402,904	81.0%	55,105	190,676
Palm Beach	721	556	77.1%	743,798	57.4%	493,701	684,745
St. Lucie	442	349	78.9%	311,507	83.3%	80,055	181,119
Florida	44,068	28,076	63.7%	13,306,231	38.4%	3,047,231	69,148

Source: 1982 Florida Statistical Abstract, pp. 269-270.

**Based on Florida County Comparison, 1980, Florida Division of Economic Development and the Farmworker Data Network.*

EDUCATION

Table XII and Table XIII explain membership and enrollment in the public school system in District IX for the school year 1980-1981. Unlike many aspects of this region, school enrollment and the racial/ethnic composition has remained relatively constant since 1976. The only noticeable increase is in students of Spanish origin.

TABLE *XII*
PUBLIC ELEMENTARY AND SECONDARY SCHOOLS: FULL-TIME EQUIVALENT MEMBERSHIP IN BASIC EDUCATION PROGRAMS, SCHOOL YEAR 1980--81

AREA	Kindergarten Through Grade 3	Grades 4 Through 9	Grades 10 Through 12	Educational Alternatives
Indian River	2,671	3,892	1,553	38
Martin	2,507	4,039	1,555	124
Okeechobee	1,501	1,932	585	469
Palm Beach	19,599	31,917	12,591	1,045
St. Lucie	4,643	6,352	1,931	61
Florida	425,899	662,336	253,600	16,419

Source: 1982 Florida Statistical Abstract, pp. 125-126.

TABLE *XIII*
PUBLIC ELEMENTARY AND SECONDARY SCHOOLS: PUPIL MEMBERSHIP IN GRADES KINDERGARTEN THROUGH TWELVE, BY RACE OR ETHNIC GROUP, FALL, 1981

		Percentage of Membership				
AREA	Total	White Non-Hispanic	Black Non-Hispanic	Hispanic	Asian/Pacific Island	American Indian/ Alaska Native
Indian River	9,126	76.27%	22.43%	1.04%	0.26%	0.00%
Martin	9,229	81.17%	14.82%	3.51%	0.48%	0.02%
Okeechobee	4,689	82.21%	9.85%	5.48%	0.21%	2.24%
Palm Beach	69,855	62.89%	29.18%	7.16%	0.61%	0.16%
St. Lucie	14,341	57.28%	41.23%	1.27%	0.16%	0.06%
Florida	1,488,073	65.51%	23.39%	8.11%	0.86%	0.13%

Source: 1982 Florida Statistical Abstract, pp. 127-128.

WELFARE

Over 25 Million dollars was spent in District IX in 1980-81 in direct assistance to the elderly, the blind, the disabled and to families with dependent children. This represented an 11.8% increase over the previous year. Okeechobee County had the largest percent increase and Indian River had the smallest increase. One-half of all direct assistance was spent in aid to families with dependent children.

TABLE *XIV*
PUBLIC ASSISTANCE: AMOUNT OF DIRECT ASSISTANCE AND AVERAGE CASES PER MONTH BY TYPE OF ASSISTANCE
FISCAL YEAR 1980--81
(AMOUNTS IN DOLLARS)

	TOTAL DIRECT ASSISTANCE		AID TO FAMILIES WITH DEPENDENT CHILDREN		OLD AGE ASSISTANCE		AID TO THE BLIND		AID TO THE DISABLED	
AREA	AMOUNT	PERCENTAGE CHANGE 1979-80 TO 1980-81	AMOUNT	AVERAGE CASES PER MONTH	AMOUNT	AVERAGE CASES PER MONTH	AMOUNT	AVERAGE CASES PER MONTH	AMOUNT	AVERAGE CASES PER MONTH
DISTRICT IX	25,570,707	11.8	12,789,376	6,452	4,514,495	3,494	375,105	184	7,891,731	4,224
INDIAN RIVER	1,933,980	10.4	998,608	538	230,840	204	20,355	11	684,197	362
MARTIN	1,430,014	13.0	795,184	401	200,359	180	21,899	11	412,572	225
OKEECHOBEE	1,022,052	14.8	485,007	255	159,032	130	16,735	9	361,278	196
PALM BEACH	16,005,207	11.9	7,330,539	3,710	3,362,572	2,503	261,201	127	5,050,895	2,709
ST. LUCIE	5,179,454	11.2	3,180,038	1,548	561,692	477	54,935	26	1,382,789	732

Source: 1982 Florida Statistical Abstract, p. 236.

In the same period of time, 6.3% of the population in District IX received food stamps at a cost of almost $30 Million dollars. Almost 11% of Okeechobee County's residents received food stamps as opposed to 4.8% of Martin County residents.

TABLE *XV*
FOOD STAMPS: VALUE OF FOOD STAMP ISSUED
FISCAL YEAR 1980--1981

AREA	Total Value of Food Stamp Issued 1980--1981 (Dollars)	No. of Persons Receiving Food Stamps	Percent of Population Receiving Food Stamps
District IX	29,781,607	54,549	6.3%
Indian River	1,830,454	3,392	5.4%
Martin	1,718,850	3,218	4.8%
Okeechobee	1,084,710	2,270	10.7%
Palm Beach	18,812,276	34,024	5.5%
St. Lucie	6,335,317	11,645	12.3%

Source: 1982 Florida Statistical Abstract, p. 238.

HEALTH STATUS

BIRTH RATE

The birth rate for District IX in 1982 was similar to the birth rate experienced by the entire State. Okeechobee and St. Lucie Counties experienced a decline in their respective total birth rates, while the other three counties indicated a small increase over the 1979-1981 birth rates. For the entire District, the non-white birth rate continued to be almost twice the white rate. Okeechobee County had the highest birth rate in 1982 (19.4 births per 1000 population) and Martin County had the lowest (12.2 births per 1000 population).

TABLE XVI
RESIDENT LIVE BIRTHS AND BIRTH RATES PER 1000 POPULATION, 1982 AND ANNUAL AVERAGES 1979--1981

	1982						1979 - 1981		
	Number of Births			Birth Rate			Birth Rate		
AREA	Total	White	Non-White	Total	White	Non-White	Total	White	Non-White
Indian River	868	686	182	12.8	11.7	19.3	12.6	11.5	19.4
Martin	889	752	135	12.2	11.3	22.5	11.3	10. 2	21.4
Okeechobee	442	397	45	19.4	19.5	18.6	21.6	21.2	23.9
Palm Beach	8,176	5,907	2,265	12.7	10.8	23.3	12.1	10.3	22.3
St. Lucie	1,640	1,023	617	16.0	12.7	28.4	16.4	13.6	26.0
District IX	12,015	8,765	3,244	13.2	11.3	23.7	N/A		
Florida	144,500	106,217	38,253	13.8	12.1	22.7	13.3	11.6	22.2

Source: Florida Vital Statistics, 1982, p. 11.

NEONATAL DEATHS

In 1982, four out of five counties in District IX had neonatal mortality rates below the State average. This is an improvement over 1981 when four out of the five counties had neonatal mortality rates above the State average. Fortunately, neonatal deaths (infants under 28 days) have seen a decline since the mid-1970's. However, three of the five counties had non-white neonatal mortality rates above the State average in 1982.

TABLE XVII
RESIDENT NEONATAL DEATHS (AGE UNDER 28 DAYS) AND MORTALITY RATES PER 1000 LIVE BIRTHS 1982 AND ANNUAL AVERAGES 1979-1981.

	1982						1979-1981 Averages		
	Number of Deaths			Mortality Rate			Mortality Rate		
AREA	Total	White	Non-White	Total	White	Non-White	Total	White	Non-White
Indian River	3	2	1	3.5	2.9	5.5	7.8	5.6	15.5
Martin	5	3	2	5.6	4.0	14.8	10.0	10.0	10.2
Okeechobee	3	2	1	6.8	5.0	22.2*	7.5	6.9	11.9*
Palm Beach	80	46	33	9.8	7.8	14.6	10.6	8.0	17.1
St. Lucie	13	5	8	7.9	4.9	13.0	8.4	8.2	8.9
District IX	104	58	45	8.7	6.6	13.9	N/A		
Florida	1,302	764	536	9.0	7.2	14.0	9.5	7.9	13.8

**Unreliable rates and ratios; i.e., those with denominator less than 100.*
Source: Flaorida Vital Statistics, 1982, p. 29.

INFANT DEATHS

In 1982, District IX had an infant mortality rate slightly below the Florida average. Although the District white infant mortality rate was lower than the State figure, the non-white rate was slightly higher. Okeechobee had the highest mortality rate in all categories and has seen an increase from the 1979-1981 period. Indian River, Martin and Palm Beach have experienced a drop in their infant mortality rates in all categories and St. Lucie has experienced an increase in their non-white rate.

TABLE XVIII
RESIDENT INFANT DEATHS (AGE UNDER ONE YEAR) AND MORTALITY RATES PER 1000 LIVE BIRTHS
1982 AND ANNUAL AVERAGES 1979-1981

	1982						1979-1981		
	Number of Deaths			Mortality Rates			Mortality Rates		
AREA	Total	White	Non-White	Total	White	Non-White	Total	White	Non-White
Indian River	6	4	2	6.9	5.8	11.0	12.6	7.8	29.1
Martin	6	4	2	6.7	5.3	14.8	14.6	13.3	20.4
Okeechobee	7	5	2	15.8	12.6	44.4*	12.8	13.0	11.9*
Palm Beach	109	63	45	13.3	10.7	19.9	15.4	11.0	26.4
St. Lucie	24	8	16	14.6	7.8	25.9	14.8	11.4	20.9
District IX	152	84	67	12.7	9.6	20.7	------------	---N/A---	------------
Florida	1,855	1,074	779	12.8	10.1	20.4	14.2	11.5	21.8

**Unreliable rates and ratios; i.e., those with denominator less than 100.*
Source: Florida Vital Statistics, 1982, p. 32.

MAJOR CAUSES OF DEATH

Heart Disease and Cancer continue to be the leading killers in the country as well as in District IX. Cerebrovascular Disease (stroke) is the third leading cause of death in all five counties. Chronic Obstructive Lung Disease, Pneumonia and Influenza, Chronic Liver Disease and Cirrhosis, Diabetes, and Motor Vehicle Accidents follow (in differing order) as leading causes of death. Of particular interest are the white and non-white mortality rates for suicide and homicide. The overall non-white population has a high incidence of homicide in comparison to a very low suicide rate. The opposite is true of the white population where the suicide rate is much higher than the rate of homicides.

Although Tuberculosis cannot be classified as a leading cause of death, it should be noted that there has been a notable increase in the incidence of the disease during the past few years. St. Lucie County had 5.9 deaths per 100,000 population due to TB in 1982 (the State rate was 1.2). The non-white population has been particularly affected by this increasing incidence of tuberculosis.

TABLE XIX
RESIDENT DEATH RATES PER 100,000 POPULATION
MAJOR CAUSES OF DEATH--1982

INDIAN RIVER COUNTY

CAUSES	Total	White	Non-White
All Causes	1,160.0	1,240.0	720.0
Heart Disease	386.0	419.2	180.4
Cancer	296.2	321.7	137.9
Diabetes Mellitus	20.6	24.0	0.0
Cerebrovascular Disease	97.2	104.4	53.1
Pneumonia and Influenza	20.6	22.2	10.6
Chronic Obstructive Lung Disease	36.8	35.9	42.4
Chronic Liver Disease and Cirrhosis	20.6	22.2	10.6
Motor Vehicle Accidents	28.0	30.8	10.6
Suicide	10.3	12.0	0.0
Homicide	14.7	5.1	74.3
Tuberculosis	1.5	1.7	0.0

Source: Florida Vital Statistics, 1982, p. 52-61.

TABLE XX
RESIDENT DEATH RATES PER 100,000 POPULATION
MAJOR CAUSES OF DEATH--1982

MARTIN COUNTY

CAUSES	Total	White	Non-White
All Causes	1,340.0	1,400.0	650.0
Heart Disease	473.5	495.2	232.8
Cancer	260.1	277.6	66.5
Diabetes Mellitus	22.0	22.5	16.6
Cerebrovascular Disease	130.8	135.1	83.2
Pneumonia and Influenza	9.6	9.0	16.6
Chronic Obstructive Lung Disease	46.8	51.0	0.0
Chronic Liver Disease and Cirrhosis	24.8	25.5	16.6
Motor Vehicle Accidents	22.0	22.5	16.6
Suicide	15.1	16.5	0.0
Homicide	9.6	4.5	49.9
Tuberculosis	0.0	0.0	0.0

Source: Florida Vital Statistics, 1982, pp. 52-61.

TABLE XXI
RESIDENT DEATH RATES PER 100,000 POPULATION
MAJOR CAUSES OF DEATH--1982

OKEECHOBEE COUNTY

CAUSES	Total	White	Non-White
All Causes	1,010.0	1,020.0	950.0
Heart Disease	347.1	368.8	164.9
Cancer	219.7	226.2	164.9
Diabetes Mellitus	13.2	14.8	0.0
Cerebrovascular Disease	83.5	78.7	123.7
Pneumonia and Influenza	22.0	24.6	0.0
Chronic Obstructive Lung Disease	26.4	29.5	0.0
Chronic Liver Disease and Cirrhosis	26.4	19.7	82.5
Motor Vehicle Accidents	43.9	44.3	41.2
Suicide	13.2	14.8	0.0
Homicide	22.0	9.8	123.7
Tuberculosis	0.0	0.0	0.0

Source: Florida Vital Statistics, 1982, pp. 52-61.

TABLE XXII
RESIDENT DEATH RATES PER 100,000 POPULATION
MAJOR CAUSES OF DEATH--1982

PALM BEACH COUNTY

CAUSES	Total	White	Non-White
All Causes	1,200.0	1,290. 0	710.0
Heart Disease	466.7	513.4	204.0
Cancer	292.1	322.0	123.6
Diabetes Mellitus	15.8	14.5	23.7
Cerebrovascular Disease	107.8	115.3	64.9
Pneumonia and Influenza	18.0	18.7	14.4
Chronic Obstructive Lung Disease	36.8	42.3	6.2
Chronic Liver Disease and Cirrhosis	17.7	18.3	14.4
Motor VehicleAccidents	24.7	25.4	20.6
Suicide	18.8	21.2	5.2
Homicide	12.4	7.7	39.2
Tuberculosis	1.9	1.3	5.2

Source: Florida Vital Statistics, 1982, pp. 52-61.

TABLE XXIII
RESIDENT DEATH RATES PER 100,000 POPULATION
MAJOR CAUSES OF DEATH--1982

ST. LUCIE COUNTY

CAUSES	Total	White	Non-White
All Causes	1,020.0	1,070.0	850.0
Heart Disease	428.1	484.9	216.6
Cancer	237.9	249.8	193.6
Diabetes Mellitus	10.7	9.9	13.8
Cerebrovascular Disease	80.9	82.9	73.7
Pneumonia and Influenza	14.6	14.8	13.8
Chronic Obstructive Lung Disease	24.4	27.2	13.8
Chronic Liver Disease and Cirrhosis	12.7	13.6	9.2
Motor Vehicle Accidents	33.2	28.4	50.7
Suicide	9.8	12.4	0.0
Homicide	13.7	2.5	55.3
Tuberculosis	5.9	0.0	27.7

Source: Florida Vital Statistics, 1982, pp. 52-61.

TABLE XXIV
RESIDENT DEATH RATES PER 100,000 POPULATION
MAJOR CAUSES OF DEATH--1982

FLORIDA

CAUSES	Total	White	Non-White
All Causes	1,040.0	1,110.0	680.0
Heart Disease	389.3	427.7	189.1
Cancer	245.5	266.3	137.2
Diabetes Mellitus	16.2	15.9	17.8
Cerebrovascular Disease	84.4	89.3	58.7
Pneumonia and Influenza	18.3	19.5	12.5
Chronic Obstructive LungDisease	34.3	38.4	12.8
Chronic Liver Disease and Cirrhosis	17.4	18.2	13.6
Motor Vehicle Accidents	25.2	26.0	21.2
Suicide	17.5	19.9	4.8
Homicide	14.2	10.0	35.9
Tuberculosis	1.2	1.0	2.3

Source: Florida Vital Statistics, 1982, pp. 52-61

MORBIDITY

Table XXV indicates common notifiable diseases in District IX during 1980. The rate of hepatitis A and Salmonellosis is much higher in rural Okeechobee County than in the remaining District or in the State. Palm Beach County had a slightly higher incidence of Hepatitis B and a significantly higher rate of salmonellosis.

TABLE XXV
CASE RATES OF COMMON NOTIFIABLE DISEASES
1980
(RATES PER 100,000 POPULATION)

AREA	*HEPATITIS A*	*HEPATITIS B*	*MEASLES (RUBEOLA)*	*RUBELLA (GERMAN MEASLES)*	*SALMONELLOSIS*
Indian River	*3.3*	*1.7*	*3.3*	*0.0*	*8.3*
Martin	*43.1*	*9.2*	*1.5*	*0.0*	*4.6*
Okeechobee	*58.6*	*0.0*	*0.0*	*0.0*	*97.6*
Palm Beach	*39.4*	*13.0*	*1.7*	*0.7*	*21.9*
St. Lucie	*20.4*	*11.4*	*1.1*	*0.0*	*9.1*
Florida Total	*23.2*	*12.5*	*4 .4*	*1.1*	*20.7*

Source: Florida Morbidity Statistics, 1980.

With the exception of Indian River County, District IX had an increase in the number of reported cases of gonorrhea from 1979 to 1980. While Palm Beach County experienced a 16.0% increase, the State of Florida had a 6.5% increase in reported cases of gonorrhea. Martin County experienced the greatest increase from 1979-1980.

TABLE XXVI
GONORRHEA--REPORTED CASES
1979-1980

AREA	*1979*	*1980*	*% Change*
Indian River	*433*	*331*	*-23.6%*
Martin	*119*	*150*	*+26.1%*
Okeechobee	*68*	*75*	*+10.3%*
Palm Beach	*3,130*	*3,630*	*+16.0%*
St. Lucie	*523*	*542*	*+ 3.6%*
Florida	*61,427*	*65,437*	*+ 6.5%*

Source: Florida Morbidity Statistics, 1980.

It appears that the incidence of both gonorrhea and syphilis is on the increase. However, Martin County has experienced a decline in reported cases of syphilis from 1979-1980. The State of Florida has experienced a 7.5% increase from 1979-1980, which is less than the increase of reported cases of primary and secondary syphilis in four of the five counties in District IX.

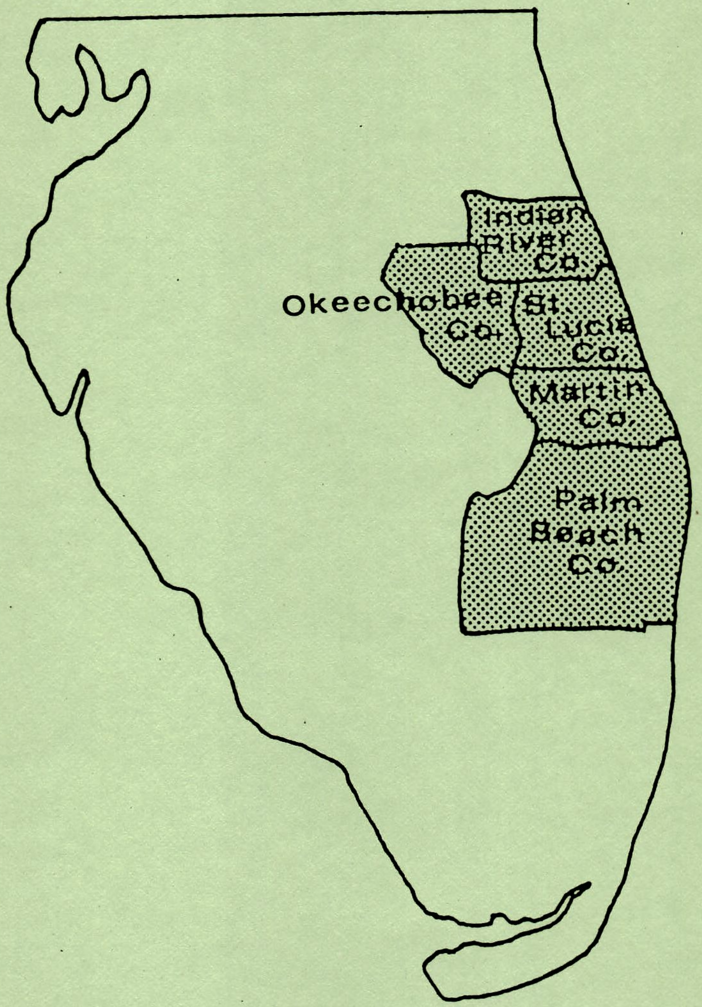
TABLE XXVII
PRIMARY AND SECONDARY SYPHILIS
REPORTED CASES
1979--1980

AREA	*1979*	*1980*	*% Change*
Indian River	*16*	*23*	*+43.8%*
Martin	*10*	*7*	*-30.0%*
Okeechobee	*0*	*2*	*--*
Palm Beach	*65*	*156*	*+140.0%*
St. Lucie	*42*	*46*	*+9.5%*
Florida	*2,099*	*2,257*	*+7.5%*

Source: Florida Morbidity Statistics, 1980, p. 67.

DISTRICT IX HEALTH PLAN

1984



DENTAL HEALTH

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DENTAL HEALTH

Introduction

Dental caries continues to be a problem affecting virtually all Americans. In fact, the problem is so pervasive that many people consider tooth decay an unavoidable part of life. Recent studies show that edentulism in adults and dental caries in children have shown a nationwide decrease and there has been an increase in the availability and quality of dental services. Nevertheless, the following conditions still persist:[1]

- *The average 17 year old has had eleven cavities*
- *Low income children probably continue to have five times more untreated decayed teeth, than high income children*
- *Twenty-nine percent of children, age 12-17 years, have severe or very severe malocclusion*
- *Forty-five per cent of the population over age 65 have no teeth at all*
- *Only about one-third of the U.S. population receives complete dental care and almost one-half of children under age 12 have not been to a dentist for treatment.*

The following statements[2] *portray the severity of dental decay:*

> *Since body tissues are destroyed and disfigurement, pain, illness, and loss of function result from tooth decay, it is defined as a disease.*
>
> *Dental decay is a chronic disease which affects nearly all human beings.*
>
> *Unless interrupted by treatment, dental decay progresses until teeth have to be removed, since decayed teeth are not self-rebuilding tissues of the body.*
>
> *Untreated decay is so common that its consequences of discomfort and loss of teeth are considered inevitable.*
>
> *The child or adult with an aching, decayed tooth and/or a swollen face cannot perform satisfactorily at school or at work.*
>
> *The increasing costs of dental treatment can be a heavy burden to the family pocketbook or community health budget.*
>
> *Badly decayed teeth can become abscessed with the spread of infection into the soft and hard tissues, and to tonsils, lymph glands, and other organs; tooth decay may lead to life threatening conditions such as bacterial endocarditis, asphyxiation, and brain abscesses.*

> *People with valvular diseases of the heart may suffer additional heart damage due to septic (infected) teeth.*

However, with existing preventive measures such as fluoridation programs, the incidence of dental decay can be reduced by almost sixty-five percent in those persons who have received adequate amounts of fluoride since birth. Other preventive measures that should be stressed are: good personal hygiene (brushing and flossing of teeth), biannual dental checkups, and good nutritional practices which limit sugar intake. A technique that complements fluoridation is the use of dental sealants. Research has found that the use of these synthetic resins on the pits and fissures of the grinding surfaces of molars can substantially reduce further tooth decay on the chewing surfaces which is, sometimes, not completely prevented by fluoridation. In December of 1983, an advisory panel at the National Institute of Dental Research, U.S. Public Health Service, recommended their use for most children.[3]

The current situation[4] *illustrates how short of the objectives of preventive dental health we presently are in the United States:*

- *Over 70 million people live on central water supplies and do not have the health and economic benefits of fluoridation.*
- *Over 35 million people live in communities that have no central water supply and the children in these communities could be benefiting from a school-based fluoride program;*
- *Although periodontal disease affects the majority of Americans over age 45, two recent statewide studies in Iowa and North Carolina show that less than two percent of the practices of dentists is in periodontal treatment;*
- *Although the United States is one of the most developed countries in the world, we are one of the few that does not have a dental care program for our children, let alone a national prevention program.*

Fluoridation is truly a preventive measure and does not merely delay the onset of dental caries. The significant reduction in dental caries as a result of fluoridation, however, must be reinforced by adequate periodontal disease prevention programs. Given the current dental behavior of the public and the small amount of periodontal treatment being provided, we may be preserving teeth in children and young adults only to have these teeth lost to periodontal disease later in life.[5]

The term, "periodontal disease", actually encompasses a number of diseases that affect the gingival tissue and supporting bone. Periodontal diseases are almost as prevalent as dental caries and affect some 75% of the adult population.[6] *However, periodontal disease is not limited to adults. Statistics from the National Health Surveys relating to periodontal disease in children reveal that 68% of youth, ages 12-17, have periodontal disease as do 39% of children, ages 6-11.*[7]

The growing realization of the primacy of the American periodontal disease problem evokes a natural interest in developing a broad strategy for preventing the disease or controlling it sufficiently to lessen its impact on society. Because it is universally *acknowledged that periodontal diseases do not yet respond to specific vaccines or chemotherapeutic agents, resources should be assigned an especially critical role in preventive efforts. These roles include personnel for health education and for all levels of prevention, diagnosis and treatment. The most important steps in the prevention of periodontal disease, as stated by the American Academy of Periodontology, are to teach the dental patient what periodontal disease is, to teach him the proper habits of mouth care and to instill the motivation that is essential if he is to carry them out.*

Current dental research is examining several experimental techniques including the development of a vaccine designed to prevent dental decay, cloning enamel genes to reproduce enamel that is virtually indistinguishable from the enamel of the tooth and the use of lasers to determine whether a beam could rearrange the molecular structure of decayed areas of a tooth to restore its original hardness.[8] *However, until such time these intervention systems are perfected and made available, the fluoridation of community water supplies remains the safest and most cost effective method of dental disease prevention available.*

HEALTH SYSTEM

Services and Settings

Public Health dentists and private dentists serve as the only sources of primary care. All states require that dental hygienists must work under the supervision of a dentist. Pharmacies and dental laboratories serve as support services for the dentist.

It must be noted that there are few preventive dental health services being provided in the community setting. Preventive dental health programs/services that should be provided by community based organizations are as follows:

1. *Fluoridation of public water supplies*
2. *School based fluoride mouth rinse programs*
3. *School and community-wide dental health education programs*

In District IX, as of December, 1983, 9.6% of the people are either being served by a fluoridated water supply or had been given approval to fluoridate their public water supply. Only Belle Glade, Fort Pierce, and Okeechobee public water systems provide water with fluoride levels adjusted for optimum prevention of tooth decay. Of special note, the recent approval by the Okeechobee City Commission to initiate fluoridation of their municipal water supply is the first approval by a city in District IX in over eighteen years. The city of Fellsmere water supply is naturally fluoridated at an optimum level. Potential fluoridation sites include Vero Beach and Sebastian whose engineers are presently developing cost estimates. If these two areas are fluoridated, then 11.9% of District IX will be served by a fluoridated water supply.

FLUORIDE WATER LEVELS FOR
BELLE GLADE, SOUTH BAY, PAHOKEE, AND CANAL POINT

BELLE GLADE - City Water Supply		
	Treated Water: 0.85 ppm	*August, 1980*
SOUTH BAY - City Water Supply		
	Finished Water: 0.08 ppm	*May, 1980*
PAHOKEE AND CANAL POINT		
	Finished Water: 0.26 ppm	*August, 1980*

Data provided by Palm Beach County Health Department Environmental Engineering & Sciences Section as referred to in Dr. Lasch's study.

In 1982, a study was completed by Alan H. Lasch, D.D.S., Assistant Dental Director, Palm Beach County Health Department, which compared elementary school students from Western Palm Beach County to determine the lifetime effects of controlled water fluoridation on decayed, missing and filled surfaces of permanent teeth. Students from the city of Belle Glade were compared to students from the adjacent cities of Pahokee and South Bay.

Students drinking fluoridated water from birth were found to have 30% fewer mean carious tooth surfaces than their neighbors who had not drunk fluoridated water from birth. When the mean values for smooth tooth surfaces only were compared, those drinking fluoridated water from birth developed 45% fewer smooth surface carious lesions. The findings from this study point to the positive effects fluoridation does have in terms of dental decay prevention.

In regard to school based mouth-rinse programs, only Palm Beach and Martin County school systems have instituted such programs. For the 1982-83 school year, the Palm Beach County program was provided for the grades K through 4 (11,400 students). In District IX, there are 58,500 children in unfluoridated areas who are not participating in the Sodium Fluoride Mouth Rinse program. This is approximately 87% of all children in District IX.

Also, the need for comprehensive health education (of which Dental Health is a major component) has been identified as a high priority need in District IX. School dental health education has been shown to have a positive effect on the students' dental care knowledge and should be instrumental in reducing dental health problems in District IX. The Palm Beach County Health Department employs a Dental Health Educator who is responsible for implementation of school dental health education. The Dental Health Educator holds approximately ten workshops a year where she informs teachers about the dental health education curriculum. The number of teachers reached in an average year totals three hundred. In order to get an estimate of how many students are "informed", we can look at the equation:

$$\text{No. of Teachers Attending Workshops} \quad \times \quad \text{Rough Class Size} \quad = \quad \text{No. of Students Informed Each Year}$$

$$\therefore\ 300 \times 30 = 9{,}000 \text{ Students Informed in a Year}$$

As of December, 1982, the predecessor organization of the District IX Health Council, Inc., the Health Planning Council, Inc., had marketed the Regional Fluoridation Program through workshops, media releases, provision of technical assistance and mailings to fourteen target populations and over 75 organizations and individuals.

System Characteristics

Cost: In 1965, consumers paid 97.2% of their dental bills directly; private insurance paid only 1.6% and public programs paid 1.2%. By 1978, 76.8% of total personal dental care expenditures came from direct payments, while private insurance contributed 19.2% and governmental programs contributed 4.1%. [9]

There has been significant growth in dental prepayment plans in the past decade. Recent data suggest that 60 million people are covered by dental insurance, or about 18% to 20% of the United States population.[10] This contrasts significantly to 1965 when fewer than two million persons received any kind of dental care through insurance proved by fewer than 100 employers.[11] It has been projected that by 1990, half of the population may have some dental care paid for by third party carriers.

If medicine provides a window into the future, then such a development should substantially increase the population's demand for care.

Availability: *Utilization trends have been influenced by the rapid growth of dental prepayment, but availability and accessibility of dental services is still not at an optimum level for District IX. Three areas of District IX have been designated as critical dental shortage areas: Belle Glade/Pahokee, downtown West Palm Beach, and Fort Pierce. Indiantown and Okeechobee have been considered possible dental shortage areas.*

Recently, Indian River County, based upon the number of indigents, has been given a priority number of "1" as an underserved area and St. Lucie County's dental indigents number has caused them to reach a priority number of "3". Also, there are no public dental health treatment programs in Indian River, St. Lucie, Martin, or Okeechobee Counties. HRS has a formula which they apply to indigent populations which indicates that an indigent population of 6100 can support one public health dentist. The State feels that the indigent population in these counties can support 3.2 times that number of dentists.

Accessibility: *Accessibility as a barrier to dental care can be measured by two indicators: travel time to dental care, and length of time an individual must wait to receive an appointment. Non-emergency care should be accessible within thirty minutes travel time and a person should not wait longer than two weeks for an appointment. Office hours of practitioners and public awareness of dental care can also provide an impact upon accessibility to dental care.*

Rural areas are generally less accessible to dental care than are urban areas because of the number of dentists. From a financial standpoint, lower income families have less accessibility to dental care than higher income families. Persons in nursing homes or other long-term care institutions as well as the home-bound have less accessibility to dental care than other population groups. Presently, dental services for the home-bound and institutionalized are minimal. At the Eckerd's Boys Camp, dental services are contracted with funding through the State level. At the new Intermediate Care Facility for the Mentally Retarded in Lantana, dental services are also provided through outside contracting. Also, the Palm Beach County Home and General Care Facility contracts with private providers for emergency dental care.

Facilities and Organizations

The traditional manner of delivering dental care--private practice--dominates all alternative systems, even when they are taken in the aggregate. Today, 95% of dental services are provided by dentists who own or work in a private practice setting. Approximately 78% of the 129,064 active civilian dentists are nonsalaried and work alone; 90% are general practitioners whose mean age is 45. Another 4.4% practice with at least one other dentist, and an additional 4% are in formal partnerships. Of interest is the fact that 20% of all dentists who have been in practice for one year or less belong to groups, partnerships or associateships.[12]

A number of alternative dental care delivery systems have emerged and are being tested, and others are just emerging. These systems include department store practices (Jefferson Ward), hospital dental services, health maintenance organizations, preferred provider organizations, the independent practice of dental hygiene, and denturism. Although it is too soon to draw any conclusions about the efficacy and effectiveness of these systems, they merit mention here since they could possibly change the way dental care is currently delivered.

A significant feature of the dental profession is a relatively well-integrated vertical organizational structure that parallels the local/State/Federal hierarchy of government in the United States. Dentistry may be unique in that over 90% of practicing dentists are members of a mandatory three-level membership association that consists of a local (or district) and State constituent societies of the American Dental Association (ADA) at the national level.[13]

Here in Florida, the Florida Dental Association is the State association. The State is broken into six districts. The Atlantic Coast District Dental Associaton, which covers all of District IX consists of:

1. Tri-County Dental Association
    - Martin County
    - St. Lucie County
    - Okeechobee County
2. North Palm Beach Dental Association
3. Central Palm Beach Dental Association
4. South Palm Beach Dental Association
5. Broward County Dental Association
    - North half of Broward County
6. Indian River County

PROGRAM GOALS AND OBJECTIVES

Health Systems Goals

All public water supplies in District IX should provide fluoridated drinking water.

Emergency dental care should be available on a 24-hour basis to 95% of the population of District IX within thirty minutes driving time.

Regular dental care should be available to all residents of District IX, including those home-bound and in institutions, within two weeks from the time service is requested.

Dental health education should be a significant part of the health curriculum taught in grades K through 12 in all public and private schools in District IX by 1989.

The Sodium Fluoride Mouth Rinse Program should be available to all students in grades K through 8 in all of District IX.

Health Systems Objectives

By 1989, 25% of the population served by public water supplies will be drinking fluoridated water.

By 1989, emergency dental care should be available to 85% of District IX population within thirty minutes driving time.

Establish by 1989, a dental care program serving low income children, the home-bound, and those in institutions through public and private dental programs.

Implement an approved dental health education curriculum in all public schools by 1989, inclusive of periodontal disease prevention.

By 1989, 30% of the children in grades K-8 in District IX living in unfluoridated areas should be participating in the Sodium Fluoride Mouth Rinse Program.

V. ***Support efforts to identify the existing need for regular dental care by low-income children, the home-bound and institutionalized persons in District IX.***

Rationale: *Regular dental care should be available to all residents of District IX, including those home-bound, those in institutions, and low-income children who have no means to buy dental care. The District IX Health Council, in conjunction with such groups as the Council on Aging, District IX HRS, Nursing Home Administrators, and Home Health Agencies, should develop strategies to reach the appropriate entities to determine the extent of this need.*

VI. ***Develop strategies designed to measure the extent of periodontal disease in District IX. These strategies should include:***

A. ***An improved data base on the incidence and prevalence of periodontal disease.***

B. ***Determination of the level of services necessary to treat periodontal disease, with emphasis on educational services designed to teach the importance of plaque control, early intervention and comprehensive treatment.***

C. ***Coordination with County Health Departments, local dental societies and the Department of HRS in order to evaluate future recommendations to combat periodontal disease.***

Rationale: *As the incidence of dental caries decreases, the next priority in preventive dental health should be to combat periodontal disease. In order to address this issue, more preliminary information is necessary and coordination with other agencies responsible for preventive dental health is very important.*

RECOMMENDATIONS

I. ***Support efforts to secure the fluoridation of all public water supplies in District IX.***

Rationale: *The benefits of fluoridation are great. In order to support efforts to secure fluoridation, the approach should be directed toward local government. Local governments would be encouraged to undertake this project as a public health measure in much the same way as chlorine is added to water as a public health measure. Efforts directed to the local governments have succeeded in the fluoridation of 33 communities in Florida over the past two years. For every dollar spent on fluoridation, a $50 return can be expected in the form of prevented dental cavities with a concurrent reduction in dental repair costs. Community water fluoridation is the most cost effective dental disease program available to date.*

II. ***Support strategies to implement school Fluoride Mouth Rinse Programs in all public, private and parochial schools (grades K through 8) in District IX.***

Rationale: *These strategies would develop and implement school Fluoride Mouth Rinse Programs in those schools where the public water supply is not fluoridated. Present school Mouth Rinse Programs run cooperatively by County Health Units and School Boards should be expanded. This Program costs approximately 50¢ per child per year. Though this recommendation is less effective and efficient when compared to the fluoridation of public water supplies, it would still reduce tooth decay by up to 42% (as compared to 65% for fluoridating water supplies.)*

III. ***Support efforts to expand the implementation of an approved dental health education curriculum in all public, private and parochial schools (grades K through 12) in District IX.***

Rationale: *Dental health education, taught at an early age, will aid in the prevention of dental caries and periodontal disease. Good personal hygiene (brushing and flossing of teeth), biannual dental checkups and good nutritional practices which limit sugar intake, are necessary components of a healthy future.*

IV. ***Support efforts to identify gaps in the provision of emergency dental care and determine who is responsible for providing that care in District IX.***

Rationale: *Improvements are needed in District IX in regard to the provision of emergency dental care. Strategies should be developed to define and to change this situation. Area hospitals and the dental societies, along with the District IX Health Council, should be jointly responsible for developing recommendations for any needed improvements in emergency dental care services.*

FOOTNOTES

1. *Allukian, Jr., Myron: Dentistry at the Crossroads: The Future is Uncertain: The Challenges are Many. American Journal of Public Health, July, 1982; 72:653-654.*

2. *Health Planning Council, Inc.; Regional Fluoridation Program for HSA #7. December, 1979.*

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5. *Rozier, Gary R. et al: Policy Implications of the Epidemiology of Dental Diseases for the Prevention and Control of Periodontal Disease: The North Carolina Studies. Journal of Public Health Dentistry, Spring, 1983; 43:120-127.*

6. *Bureau of Economic and Behavioral Research, Council on Dental Health and Health Planning: Changes in the Prevalence of Dental Disease. Journal of the American Dental Association, July, 1982; 105:75-79.*

7. *American Association of Public Health Dentists Subcommittee on Preventive Periodontics: Periodontal Disease in America - A Personal and National Tragedy. Journal of Public Health Dentistry, Sprin, 1983; 43:106-117.*

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9. *Gift, Helen C. et al: Attempts to Control Dental Health Care in Costs: The U.S. Experience. Social Science and Medicine, 1981; 15A:767-779.*

10. *Wotman, Steven and Goldman, Harriet: Pressure on the Dental Care System in the United States. American Journal of Public Health, July, 1982; 72:684-689.*

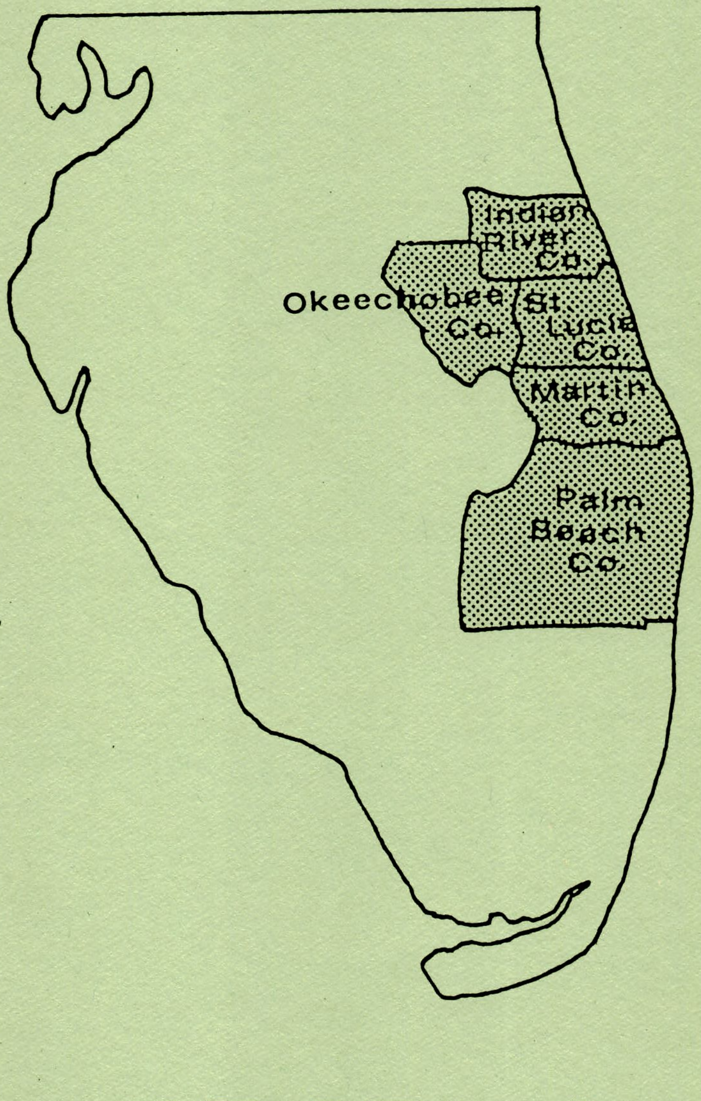
11. *Ibid: No. 9; Pg. 767-779.*

12. *Rovin, Sheldon and Nash, Jonathan: Traditional and Emerging Forms of Dental Practic Cost, Accessibility, and Quality Factors. American Journal of Public Health, July, 1982; 72:656-662.*

13. *Lipscomb, Joseph and Douglass, Chester: A Political Economic Theory of the Dental Care Market. American Journal of Public Health, July, 1982; 72:665-675.*

DISTRICT IX HEALTH PLAN

1984



EMERGENCY MEDICAL SERVICES

EMERGENCY MEDICAL SERVICES

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EMERGENCY MEDICAL SERVICES

INTRODUCTION

Emergency Medical Services (EMS) provide immediate medical care to prevent loss of life or the worsening of physiological or psychological illness or injury. The development of EMS in the United States has occurred at an extremely rapid pace within the last eighteen years. Until 1966, Emergency Medical Services in the United States was, perhaps, the most neglected area of medical and public safety service. The active input and interest of physicians regarding the need for improvements in emergency medicine contributed to the inclusion in the National Highway Traffic and Safety Act of 1966, of a standard which required each state to take definitive actions toward providing better emergency medical care for traffic accident victims.

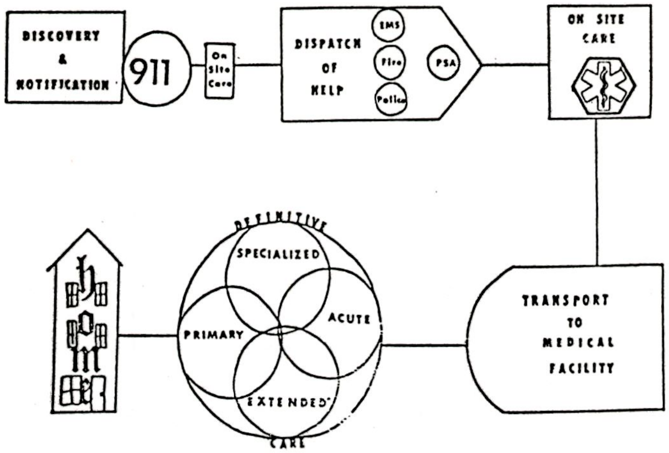
Prior to 1970, emergency services as we know them today, did not exist in District IX. At that time, most people considered emergency services only in regard to ambulance services. These services were mostly provided by funeral homes, volunteers, and private ambulance companies utilizing very poorly trained (by today's standards) personnel. The Emergency Medical Services Systems (EMS) Program (Title XII of the Public Health Service Act) was established in 1973. The purpose of the program was to provide assistance and encouragement for the development of comprehensive emergency medical services systems throughout the country and, thereby, improve the quality of patient care and reduce morbidity and mortality. The Federal EMS Act of 1973 has been amended three times, most recently in 1979, to provide funding for trauma centers and poison control centers.

Due to the Federal EMS Act of 1973 (P.L. 93-154), major improvements were made to both the State of Florida's and to District IX's EMS Systems. The Office of Emergency Medical Services (Health Program Office, HRS) operates under the guidance of the Comprehensive State Emergency Medical Services Act developed by the Florida Legislature and the Governor in 1973 (Chapter 401, Florida Statutes). In District IX, improvements on a region-wide basis consisted of, at a minimum, utilizing better trained ambulance personnel (emergency medical technicians), upgrading local hospital emergency departments through providing 24-hour service and utilizing physicians especially trained in emergency medicine. By 1978, Okeechobee County, St. Lucie County and some communities within Palm Beach County had initiated paramedic services. Also, by 1978, all five counties had made major improvements in their emergency comunications systems.

Since the passage of the Federal EMS Act, emergency services are now discussed and defined in system terms as: an arrangement of manpower, facilities and equipment designed for the effective and coordinated delivery of health care services under emergency conditions. Figure 1, below, illustrates graphically this total EMS system with the six basic elements that are essential for quality emergency care listed below.

Figure 1

EMS SYSTEM



SIX BASIC ACTIONS OF A QUALITY EMS SYSTEM

ELEMENTS	MANPOWER, EQUIPMENT, FACILITIES NEEDED TO PROVIDE SERVICES
1. Prompt discovery and notification of illness or injury	1. Informed public and first responder public servants
2. Prompt dispatch of help	2. Centralized communication system + 911
3. On-Site Care	3. Trained public (CPR) EMTs Paramedics, Fireman, Policemen, and other public service personnel
4. Transportation to appropriate emergency facility	4. Land, air, water vehicles
5. Initial care at emergency facility	5. Closest and most appropriate hospital emergency department or emergency care facility
6. Definitive care	6. Appropriate hospital, specialty care center (spinal, burn center, etc.), extended care center located within region or in another region or state

*A quality EMS system should provide for transfer of patients to facilities and programs which offer followup care and rehabilitation as is necessary to effect maximum recovery of patient. "Followup care and Rehabilitation" includes physical and psychiatric care and vocational rehabilitation.

A quality EMS system has been further defined (P. L. 93-154) to contain the following five basic and ten support elements.

BASIC ELEMENTS

1. Manpower
2. Training
3. Communication
4. Transportation
5. Facilities

SUPPORT ELEMENTS

1. Critical Care units
2. Public Safety agency interfaces
3. Community participation
4. Guarantees of accessibility to care
5. Logical transfers of patients
6. System evaluation
7. Disaster planning
8. Mutual aid agreements
9. Standardized medical record keeping and data collection
10. Public information and education

The above basic and support elements are not all inclusive and can be modified based upon increases in the state of the art and how EMS needs are defined locally. Conspicuously absent from this list is the development of suitable funding mechanisms. The reason for this is that the above EMS system was designed as part of a Federal Grant Program which provided the majority of funding to participating regions throughout the country. Also, if similar systems are to be set up locally without the aid of Federal funds, a great deal of attention must be given to how to make such a system work within the limits of local resources.

As a patient's needs do not recognize political or organizational boundaries, and considering the sheer numbers of people and organizations and political subdivisions that must interact to the best interest of the patient, sound management and coordination practices are a must at the local, regional, and State program level.

Due to the type of care being provided and to the varied and often adverse circumstances under which it must be provided, EMS requires a great deal of specialized equipment and manpower, both in the field and in health care and support facilities. This need, especially for specialized medical, communication, and transportation equipment, places a high priority on making maximum use of available EMS resources.

As defined in Florida law, there are two levels of Emergency Medical Services. "Basic Life Support" means treatment of life-threatening medical emergencies by a qualified person through the use of techniques such as patient assessment, basic cardiopulmonary resuscitation, splinting, obstetrical assistance, bandaging, administration of oxygen, application of medical antishock trousers, and other techniques described in the Emergency Medical Technician Basic Training Course Curriculum of the United States Department of Transportation. "Advanced Life Support" means treatment of life threatening medical emergencies through the use of techniques such as endotracheal intubation, the administration of drugs, intravenous fluids, telemetry, cardiac monitoring and cardiac defibrillation, by a qualified person.

The qualified personnel are defined as fellows. "Emergency Medical Technician (EMT)" means any person who is trained in basic life support and who is certified by the Department of Health and Rehabilitative Services to perform such procedures in emergency situations. "Paramedic" means a person certified by the Department to perform basic and advanced life support services as defined above.

The National Academy of Sciences has estimated that 60,000 deaths from traumatic injury could be avoided across the United States through improved emergency medical services. The American Heart Association estimated that between 15% and 20% of prehospital coronary deaths are preventable if proper care were administered at the scene en route to an appropriate medical facility. It was also estimated that 5,000 deaths each year caused by drowning, poisoning, and drug overdose could be prevented with improved EMS. [1]

Major cardiovascular diseases, accidents, suicides and homicides are among the leading causes of death in District IX. Each of these causes is characterized by a sudden onset of illness or traumatic injury. As stated previously, it is generally acknowledged that a quality EMS System could prevent 15% of these deaths. Another readily available indicator that can be used to determine the impact of an improved EMS System is the resident crude death rate which represents deaths in District IX from ALL causes. It is nationally accepted that a quality EMS System can reduce this rate by as much as 10%. The following table illustrates the growth of population in District IX from 1979 to 1982 and the numbers of deaths from Sudden Onset Illness/Traumatic Injury* (SO/TI) and total deaths from 1979 through 1982.

TABLE I

DISTRICT IX: POPULATION GROWTH, THE NUMBER OF DEATHS FROM ALL CAUSES, AND THE NUMBER OF DEATHS FROM SO/TI ---- 1979-1982.

Year	Population	% Change from Previous Year	Deaths from All Causes	% Change from Previous Year	Deaths from SO/TI	% Change from Previous Year
1979	785,342	+6.6%	8,957	+5.9%	5,674	+14.0%
1980	821,589	+4.6%	9,657	+7.8%	5,973	+ 5.3%
1981	875,070	+6.5%	10,441	+8.1%	6,514	+ 9.1%
1982	909,461	+3.9%	10,634	+1.8%	6,552	+ 0.6%

Source: Florida Vital Statistics, HRS, 1979, 1980, 1981, 1982.

During the 1981-1982 program year, two major improvements occurred in District IX. Palm Beach County's 911 System became operational and Martin County's tax supported paramedic program became operational. These improvements helped to stem the increase in resident deaths from sudden onset illness/traumatic injuries in District IX but we need to evaluate each county, individually, in order to attain a clearer picture of the situation.

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*Sudden Onset Illness/Traumatic Injuries include major cardiovascular diseases, accidents, suicides and homicides.

TABLE II

CRUDE RESIDENT DEATH RATES PER 1,000 POPULATION

AREA	1979	1980	1981	1982
Indian River	11.2	11.3	11.1	11.1
Martin	13.8	12.2	12.6	12.2
St. Lucie	10.9	10.5	10.9	10.2
Okeechobee	9.4	9.3	11.2	10.1
Palm Beach	11.3	12.0	12.1	12.0
District IX	**11.4**	**11.8**	**11.9**	**11.7**
Florida	**10.6**	**10.6**	**10.7**	**10.4**

Source: Florida Vital Statistics, HRS, 1979, 1980, 1981, 1982.

TABLE III

RESIDENT SUDDEN ONSET ILLNESS/TRAUMATIC INJURY (SO/TI) RATES PER 1000 POPULATION

AREA	1979	1980	1981	1982
Indian River	7.2	6.5	7.0	6.3
Martin	8.8	7.8	7.9	7.6
St. Lucie	7.3	6.8	6.8	6. 7
Okeechobee	5.9	4.4	6.9	6.8
Palm Beach	7.1	7.5	7.6	7.3
District IX	**7.2**	**7.3**	**7.4**	**7.2**
Florida	**6.5**	**6.5**	**6.6**	**6.3**

Source: Florida Vital Statistics, HRS, 1979, 1980, 1981, 1982.

These indicators need to be followed through for the next several years so that we can establish trends in the amount of impact EMS Systems have on these death rates. However, the potential benefits of a quality EMS System extend beyond the saving of lives; a high quality EMS System could also reduce the amount of permanent disabilities resulting from traumatic injuries and sudden onset of illness due to quicker receipt of quality care both on site and at appropriate institutions.

FIGURE 2: RESIDENT DEATH RATES PER 1000 POPULATION

Figure 2a: Indian River County

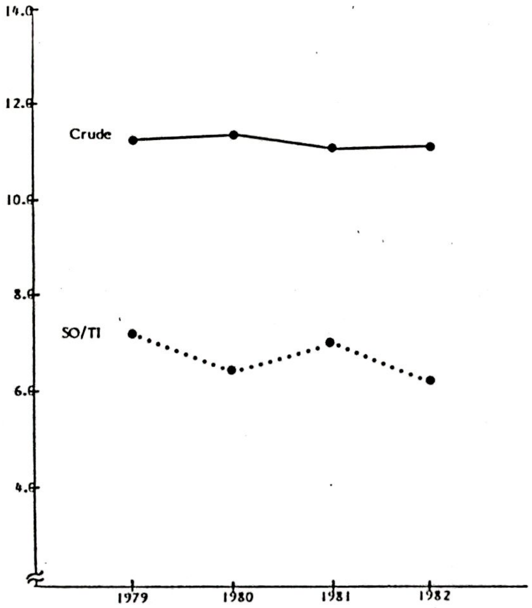


Figure 2b: Martin County

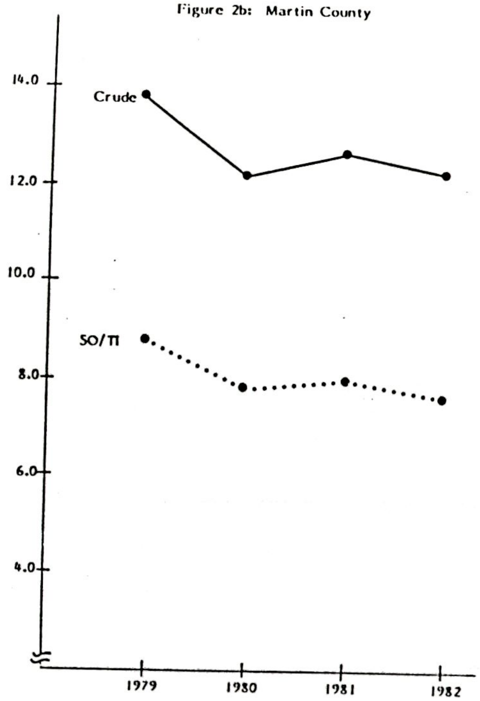


Figure 2c: St. Lucie County

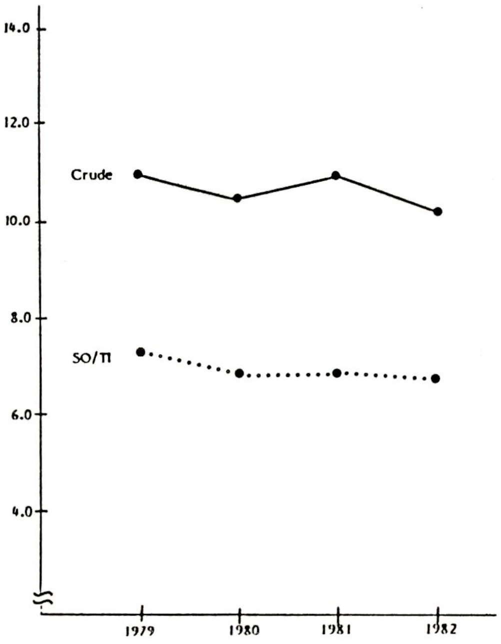


Figure 2d: Okeechobee County

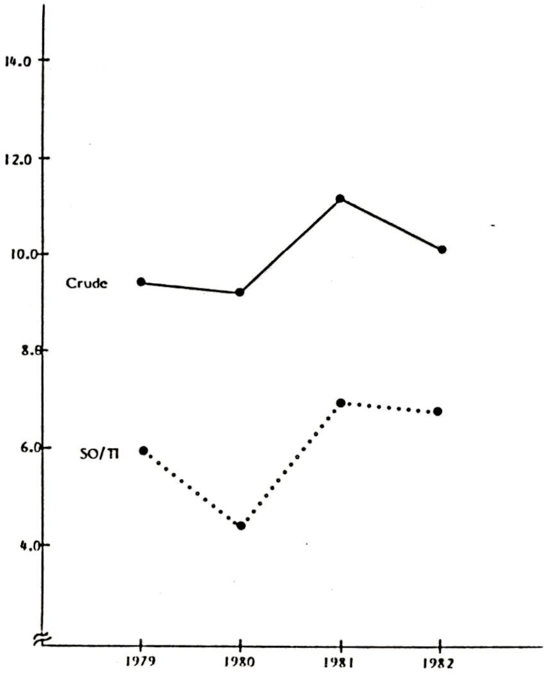
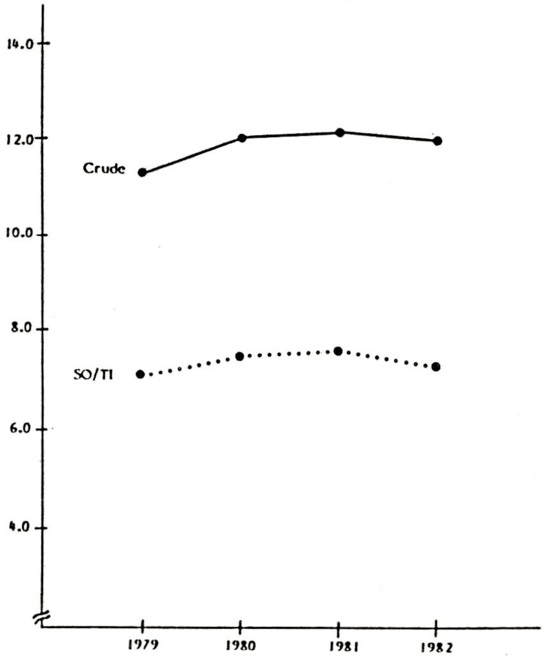


Figure 2e: Palm Beach County



On October 1, 1983, Florida enacted into law a statute that affects every restaurant in regard to emergency first aid to choking victims. It stipulates that an approved maneuver (e.g., Heimlich Maneuver or American Heart Association) be posted in all restaurants and that employees be trained in the procedure. The text of the law is as follows:

> Section 1. Section 509.213, Florida Statutes is created to read:
> 509.213 Emergency first aid to choking victims--
> (1) Every public food service establishment shall post a sign in a conspicuous place in the establishment accessible to employees, which sign illustrates and describes the Heimlich Maneuver procedure (or another approved method such as the American Heart Association recommendations) for rendering emergency first aid to a choking victim.
> (2) The establishment shall be responsible for familiarizing its employees with the method of rendering such first aid.
> (3) This section shall not be construed to impose upon a public food service establishment or employee thereof a legal duty to render such emergency assistance and any such establishment or employee shall not be held liable for any civil damages as the result of such act or omission where the establishment or employee acts as an ordinary reasonably prudent man would have acted under the same or similar circumstances.

SERVICES AND SETTINGS

TABLE IV
EMERGENCY MEDICAL SERVICES AND SETTINGS

SERVICES	SETTINGS						
	Home	Mobile	Ambulatory	Short-Stay In-Patient	Long-Stay In-Patient	Free Standing Support	Community
Health Promotion and Protection				Hospitals			County Govt. Heart Assn. Red Cross School System
Diagnosis and Treatment		Ambulance Services Fire Rescue Law Enforcement	Hospitals Doctors	Hospitals Doctors	Doctors		
Personal Health Support Services						Blood Banks	County Govts. Civil Defense
System Enabling							County Govt. District IX Health Council Treasure Coast Regional Planning Council District IX HRS County Health Units Municipalities

Though not yet available to all residents of District IX, freestanding emergicenters represent one of the fastest growing sections of health care delivery in the United States and their impact on the future trend of medical practice is certain to cause some radical changes. The term "emergicenters" does not apply to a single type of facility but, in fact, is a term which has been applied to a range of freestanding ambulatory care facilities.

The differences among the types of facilities known as emergicenters relate to their capabilities. Three general types of facilities exist across the country. One type has medical care capabilities very similar to hospital emergency rooms in that they are open continuously, provide episodic care for a range of illnesses/injuries including those that are life-threatening, and are staffed by emergency physicians. The primary distinction between these true emergency centers and hospital based emergency rooms is that these centers are freestanding and frequently independent of hospital ownership or control. While first established in 1973, these types of emergicenters still number less than a dozen, nationally. A second type of emergicenter, which can be referred to as an "urgent care center", is staffed and equipped to provide care for minor emergencies. Urgent care centers generally have the capability of evaluating and stabilizing (not treating) life and limb-threatening illness and injuries in the event such patients present themselves. To do so, they employ emergency physicians and maintain certain key pieces of emergency equipment. A third type of facility is sometimes also referred to as an emergicenter. However, its capabilites are simply those of an extended hours "primary care center" or physician's office. Here in District IX, the majority of the centers appear to be primary care centers. In Palm Beach County, the Emergency Medical Services Division is attempting to define the existing centers by having their administrators fill out a survey form addressing each center's capabilities.

Typically, the centers are located in heavily-trafficked suburban areas such as major shopping centers or strategic intersections. Most emergicenters are open seven days a week, including holidays, from 10-16 hours a day, depending upon the need in their areas of operation. Patients do not need appointments and are treated within 15-20 minutes after arriving. There is supposed to be a licensed physician and nurse on duty at all times and other appropriate ancillary personnel and clerical support.

Medical treatment is readily available for a variety of episodic injuries and illnesses such as cuts, lacerations, sprains, fractures, dislocations, flu, sore throats, childhood diseases, accidents and minor job-related injuries.

What these primary care type emergicenters do not treat are major trauma and illnesses regarded as life or limb threatening.

A 1972 Health Planning Council study of Palm Beach County hospital emergency departments showed that only 48% of emergency department visits were valid emergencies. The greater proportion of the remaining 52% most likely could have received appropriate treatment in a less expensive emergicenter or other primary care setting. A more recent study by the Indiana Hospital Association noted that half the people who go to a hospital emergency department have non-emergency conditions. Only 5% of the patients were judged to be in life-threatening situations, 45% were considered to be urgent, but nearly 83% were treated and released. The increasing demands put upon the hospital emergency department have been due to the fact that, until the emergence of freestanding centers, there has been no place to receive medical attention after regular physician's hours or on weekends except in the hospital emergency department. Therefore, these centers would have a definite impact on health care delivery in District IX once they are established throughout the District. In the future, it might be possible to refer ambulatory non-emergency situation patients to the hospital's own primary care center or to another local center.

SYSTEM CHARACTERISTICS

Availability

The major service gap exists within the transportation component of District IX's EMS System in that advanced Life Support (paramedic) Services are not uniformly available to all areas of District IX. There have, however, been major improvements made in the last few years. Currently, Okeechobee, St. Lucie, Martin and most of Palm Beach Counties provide paramedic services to their residents. To date, paramedic services are not available to all residents of Indian River County.

In regard to paramedic services, there is still the problem of having enough quality paramedics. In Palm Beach County, it appears that the supply of paramedics is in tune with the demand, but in other counties, such as St. Lucie, the supply is still not adequate. Indian River Community College provides paramedic training for the four northern counties and has recently instituted a one-year program to replace its former two-year associate degree program in order to make it comparable to other programs across the country. This program will help to train paramedics fast enough to meet local needs. Also, the State EMS program and local training programs are working together to achieve better preparation of students taking the State Certification Examination required to become a practicing paramedic. The most recent graduating class of paramedics from Palm Beach Junior College achieved an 88% pass rate on the State Certification which is higher than the State average.

Under availability, there is another problem that persists in District IX. The County Health Departments and the Veterans' Administration are two providers who are totally closed at 5:00 p.m. and on weekends. It is impossible to transfer one of their patients to Miami for further treatment without action by one of these providers because physicians refuse to accept responsibility for "over the highway" transport. A twenty-four hour telephone answering service would alleviate this problem.

Accessibility

Initial access to local emergency transportation services and facilities is not a major problem. All five counties have an operational 911 communications system. It is important to note that the design of regional EMS telecommunications can act either as the necessary glue to bond all system components into an organized, cohesive structure, or can support the existence of a fragmented nonsystem in which a multitude of communications linkages serve to isolate the critical patient from necessary EMS intervention and treatment.[3]

Medical control, also termed physician direction, is the single most visible element of the EMS communications system from the interagency viewpoint in an optimum situation. Before medical control can be effected, all acute care facilities must be categorized and formal transfer arrangements among these hospitals must be agreed upon. Interhospital physician consultation, treatment protocols, transportation and equipment arrangements, professional accompaniment, and standard patient record-keeping procedures must be included in these agreements. Triage protocols should be developed for all emergent critical care patients and should directly reflect facilities categorization. Treatment protocols do not constitute a loss of freedom for individual health care providers to express themselves in terms of the kinds of care rendered to emergency patients because, in an EMS System, providers do not, individually, render care--the EMS System does, and it does so as a team.[4]

District IX has a severe problem in regard to access to specialty or more definitive care not available at local hospitals. In many cases, patient needs dictate that patients be transferred to another hospital on an inter/intra regional basis to receive a more specialized level of care. Access to this level of care is not currently guaranteed, regardless of ability to pay, through formal inter-hospital transfer and payment agreements.

A specific problem exists in the Western portion of Palm Beach County in regard to transfer protocols. In Pahokee and Belle Glade, it is difficult to transfer a critically injured or ill patient to coastal hospitals. These small rural hospitals do not have most of the specialized equipment located in the coastal hospitals. At present, the real problem of such transfers involves the indigent where some guarantee for payment must be made and a hospital must accept the transfer. On the coast, their transfer problems are limited to transfer of patients for out-of-District specialized care and, in Belle Glade and Pahokee, the problem involves transfer to a higher level of care. It is really the same problem though geographic isolation places a further burden on the situation for Western Palm Beach County.

Continuity

Continuity has to do with those aspects of the EMS System which increase the degree of coordination between various system components and with how quickly and smoothly a patient receives all required emergency services. Delays or interruptions in receipt of required services should be minimized to the extent possible.

Presently, continuity problems still exist at both county and regional levels. At the county level, there is a need for strong county-based programs consisting of an EMS Council with adequate staff support, expertise and consumer input to plan, develop, and coordinate county EMS programs. Palm Beach, St. Lucie, and Martin Counties have EMS Councils that meet monthly to strive to resolve these continuity problems.

It is essential that these county programs have strong medical input and are organized to allow for medical control of training and performance of medical personnel. Physicians should also control the quality of on-site/institutional care to be provided and designate who provides it. Each county program should be responsible for the day-to-day operational problems of emergency services. Currently, most programs in the county lack sufficient medical involvement and control to assure that all citizens within District IX receive optimum continuity and uniform quality emergency care.

The local medical establishment needs to address the following local EMS needs:

1. Categorization of hospitals to determine the exact level of care each can provide and the categories of patients to whom each is best capable of providing quality emergency and definitive care. Certain hospitals should also be designated as Level III trauma centers.*

2. The development of uniform treatment protocols to assure quality on-site and institutional care and to determine when and where patients should be transferred to receive a higher level of care.

3. The development of inter-hospital transfer agreements which guarantee patients access to specialty care, regardless of ability to pay. Transfers to specialty care centers must be assured with a minimum of interruptions and delays; i.e., quick transfers to patients with serious spinal injuries to a center which specializes in those injuries can mean the difference between full recovery and total disability for the remainder of a life span.

4. Special attention must be given to the development in local programs of mutual aid agreements, both among political subdivisions and emergency transport services to allow for rapid deployment of emergency services during disaster situations or in other situations involving multiple injuries or illness.

5. At the regional level, similar components are needed. It is desirable to have both a regional EMS coordinator and an EMS Council. This Council would be responsible for coordinating EMS standards and operating procedures throughout the region. Also, many intra/inter regional problems need attention and can best be handled at the regional level.

It is essential to have several counties operating together as a regional unit when patient needs or the situations warrant.

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*There are three levels of trauma centers as defined by the American College of Surgeons in the standards entitled "Hospital Resources for Optimal Care of the Injured Patient" and adopted into Florida Statutes. Level I is the highest level available and is awarded to teaching hospitals only. Level II requires most of the same services available as Level I but allows for services to be promptly available and not necessarily on the hospital campus. Level III requires services above the level of an excellent emergency room.

Quality

Of the fifteen EMS System components, two still require attention with regard to increasing their quality. These are the education and transportation components.

Public education is important for several reasons. First, the public must know how to utilize and to participate in its EMS System. Second, a quality community-based EMS costs a great deal of money. It is usually very difficult for government to commit such a large amount of funding without solid public understanding and support. There are, currently, no organized EMS public education programs to generate needed public understanding and support other than episodic media releases.

Public education has been increasing in such areas as learning the techniques of cardiopulmonary resuscitation (CPR). Many local groups have sponsored classes in order to learn CPR. Palm Beach Junior College offers a course that teaches day care center personnel to render primary care treatment to children in the early stages of illness or injury. They also offer an 8-hour First Aid/CPR seg-ment with the goal in mind to certify all of the estimated 2000 Palm Beach County workers.

Other educational programs at Palm Beach Junior College include:

1. All Allied Health students are trained in CPR.
2. The general First Aid course required by many degree programs teaches Heartsaver.
3. The Police Recruit Class (training law officers for the County) are taught the First Responder's course.
4. All the Paramedic personnel are instructed in ACLS (American Heart Association) as part of their curriculum.
5. Palm Beach Junior College and the local American Heart Association conduct ACLS training and refresher courses each year to medical personnel. They also train instructors for ACLS.

District IX's transportation component has been improving. In 1976, the average response time (time from receipt of call to on-scene arrival) was approximately 11 1/2 minutes. In Palm Beach County, from October, 1982 through September, 1983, there was a total of 40,034 calls with an average response time of 7 minutes. EMS transport vehicles (with appropriately trained personnel) should be able to respond within five (5) minutes in most cases. This guideline has been determined by the needs of a heart attack victim who must receive adequate care within five (5) minutes so that brain damage doesn't occur from lack of oxygen.

Each year the Clinical Conference on Pre-hospital Emergency Care sponsors an Advanced Life Support Contest. On July 7, 1983, thirty-six paramedic teams were judged as to how well they functioned independently in difficult situations. The paramedics from the Boca Raton Fire Department emerged as the 1983 champions with the Del Trail Fire Department from Delray Beach in second place.

Cost: It is very difficult to determine the actual cost of the current District IX EMS System because of the multiple and inconsistent funding mechanisms. Emergency services are currently funded through local taxes (county, municipal, special tax districts), private grant funds, donations, patient billing, Federal and State funds and other sources such as United Way. This type of multiple funding causes many problems. First, it is very difficult to realize actual cost when a community believes that it is receiving a lot of service for very little "noticeable" dollars being spent; i.e., donations to volunteer organizations are not accurately accounted for as opposed to county government funds being highlighted in yearly budget approval processes. Second, a quality EMS System is dependent on consistency of funding since emergency services must be delivered on a 24-hour-a-day, seven-day-a-week basis. Unless an adequate level of continued funding can be guaranteed, quality of services is endangered.

When a governmental organization makes a serious committment, over-all quality can be greatly increased. EMS personnel are paid better and receive better continuing education. Communication systems are upgraded and, finally, the community-supported systems provide advanced life support services (paramedics) which must be tightly controlled due to the high level of on-site care provided and the expensive and highly technical equipment involved. Because paramedic services must have close medical supervision and must maintain quality on-site care on a 24-hour-a-day, 7-days-a-week basis to all citizens within their service areas, it is usually necessary that such services be provided by a governmental unit (county, municipal, or special taxing district) to assure a consistent and uniform funding base. Also, emergency transport involves a large number of false calls and provision of service to low density rural or suburban areas. It is not economically feasible for private fee for service transport services to provide such services. Almost all private companies agree that they are most suited to providing non-emergency transport services where the situation is more controlled and payment is more readily assured. However, there have been reports of duplicative services at the emergency scene, itself, and this also increases cost.

The major decision that has to be made regarding cost is either to maintain multiple, non-community based funding or to have an

EMS System which is tax supported at an approximate rate of $8.00 per capita per year.* Most good EMS Systems have a strong tax supported component in conjunction with private and volunteer elements. Is there room for all?

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*Palm Beach County Department of EMS, in a 1981 study, determined that it would cost $8.16 per capita to provide Emergency Transportation Services (Basic/Advance Life Support) to all citizens of Palm Beach County. A comprehensive system to include other elements (communications and administrative elements) may cost from $10 to $12 per capita or over $7 Million dollars for District IX.

PROGRAM GOALS AND OBJECTIVES

Health Systems Goals

District IX's EMS System should be capable of providing each resident accessibility to quality emergency care.

District IX's EMS System should aid in the reduction of the overall death rate and the sudden onset illness/traumatic injury death rate in this area.

District IX's EMS System should be capable of delivering on-site medical care to 95% of the Area's population within a response time of five (5) minutes.

Health Systems Objectives

By 1989, administrative and coordination elements; i.e., county/regional programs, coordinators and EMS Councils, should be effective/efficient in identifying and resolving EMS problems regarding all fifteen components of a quality EMS System.

By 1989, all EMS services (including central dispatch centers) should be in compliance with the State of Florida's EMS Communication Plan.

By 1989, emergency care should be available to 90% of the population within a response time of five (5) minutes.

By 1989, the local physicians and hospitals of District IX should categorize all hospitals to determine the exact level of care each can and/or should provide and to determine where and when emergency patients should be transported to receive the most appropriate emergency and definitive care as determined by patient needs.

By 1989, the local physicians and hospitals of District IX should develop uniform treatment protocols to assure quality on-site and institutional care and to determine more accurately when and where patients should be transported to receive a higher level of care than is available in District IX.

By 1989, the hospitals within District IX should develop and implement inter-hospital transfer agreements with those hospitals to which they normally transport patients for specialty care; to assure all citizens of District IX equal access to specialty or more definitive care with minimum interruptions in service regardless of ability to pay.

By 1989, local emergency services and political subdivisions should establish necessary mutual aid agreements to assure that these services are available to the citizens of District IX during times of natural and/or man-made disaster or those situations which involve multiple injuries or illnesses.

By 1989, EMS public education programs should be available to all citizens of District IX. These programs should emphasize the importance of having a quality EMS System and of including the assurance that the majority of citizens (and visitors, if necessary) know how to: (1) Use the 911 system and obtain emergency services, (2) utilize the system properly, and (3) provide first aid and CPR (a minimum level of on-site care). Public education programs should also stress that visitors bring their medical history with them, including such vital information as EKG strips.

By 1989, the number of non-emergent emergency department visits should be reduced by 25%. (In 1972, a Health Planning Council study showed that 52% of the patients admitted to emergency rooms could have received appropriate care in a less expensive primary care setting.)

By 1989, all county EMS programs should develop more stabilized and consistent funding mechanisms in order to guarantee uniform quality emergency services on a 24-hour, 7-day a week basis with minimum interruptions in service to all citizens of District IX. (These mechanisms should not preclude the use of those resources, manpower, funds, equipment, etc. which are volunteered by communities throughout District IX but, instead, should provide for a well defined, effective and efficient use of these resources.)

RECOMMENDATIONS

I. Support cooperative efforts among concerned Federal, State, regional and local entities to promote and provide consultation and assistance for the implementation of county comprehensive EMS programs.

> Rationale: It is expected that, through the promotion of strong county based EMS programs, the priority of EMS will be raised and county governments will gain the needed manpower, expertise and local support to improve their EMS Systems continually. Those assisting counties in improving EMS programs should strive to gain community acceptance and involvement, to assist in determining required administrative procedures, guidelines and policies, and to assist in drafting enabling ordinances and regulations. Coordination between these entities will result in improving the patient's ability to enter the EMS System quickly and to move smoothly through the System while receiving appropriate quality care.

II. Support efforts to develop and implement an EMS Regional Program capable of planning, developing and coordinating a five-county EMS System.

> Rationale: Both regional and county programs are needed to coordinate the independent five-county programs. The Regional Program would support the county programs. For example, critical patients must be smoothly transferred on an inter-county/regional basis so that they may receive the proper level of care. In order that these inter-county/regional transfers are handled smoothly, a regional program is essential.

III. Support strategies that would aid all of the hospitals in District IX to expand their roles in respect to developing a quality EMS System for this region. Specifically, hospitals should be highly supportive of developing the following elements of a quality EMS System:

1. **Categorization of hospitals to determine the level of care each can provide.**
2. **Development of uniform treatment protocols to assure quality on-site and institutional care.**
3. **Development of inter-hospital transfer agreements among hospitals in order to assure all citizens of equal access to specialty or more definitive care with minimum interruptions in service, regardless of ability to pay.**

> Rationale: Currently, all county EMS programs in District IX lack sufficient medical involvement and control to assure that all citizens within the region receive optimum continuity and uniform quality emergency care.

It is essential that hospitals address the following EMS needs:

1. Categorization of hospitals to determine the exact level of care each can provide and the categories of patients for whom each is most capable of providing quality emergency and definitive care. Certain hospitals should also be designated as Level III trauma centers.*
2. The development of uniform treatment protocols to assure quality on-site and institutional care and to determine when and where patients should be transferred to receive a higher level of care.
3. The development of inter-hospital transfer agreements which guarantee patients' access to specialty care, regardless of ability to pay. Transfers to specialty care centers must be assured with a minimum of interruptions and delays; i.e., quick transfers of patients with serious spinal injuries to a center which specializes in those injuries can mean the difference between full recovery or total disability for the remainder of a life span.

IV. Study county-based EMS delivery systems and recommend how systems costs can be reduced. The following studies should be given high priority:

a. the feasibility of a one-tier system for Palm Beach County.

b. the sharing of communications among like services.

c. the sharing of facilities among like services.

Rationale: During this era of rising health care costs and limited health care resources, cost containment in both the public and private sector must be given a high priority. With respect to EMS, the above cost containment strategies could markedly reduce EMS system costs. Okeechobee County, in conjunction with the Health Planning Council, recently implemented the sharing of County Fire and EMS communications and facilities for an ongoing annual savings of $50,000 - $70,000 for the Okeechobee County budget. Further cost containment studies by the local Council would be a catalyst for other county EMS programs to achieve similar cost savings.

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*There are three levels of trauma centers as defined by the American College of Surgeons in the standards entitled "Hospital Resources for Optimal Care of the Injured Patient" and adopted into Florida Statutes. Level I is the highest level available and is awarded to teaching hospitals only. Level II requires most of the same services available as Level I but allows for services to be promptly available and not necessarily on the hospital campus. Level III requires services above the level of an excellent emergency room.

FOOTNOTES

1. Kennedy, Senator Edward M.: Federal EMS Legislation. Emergency Medical Services, January/February, 1982; 11:11-12.

2. Luther, Diane: Freestanding Emergency Centers. Emergency Medical Services, September/October, 1982; 11:31-33.

3. Willey, Anita L. et al: Total Telecommunications Interface for a Coordinated EMS System. Emergency Medical Services, July/August, 1982; 11:42-47.

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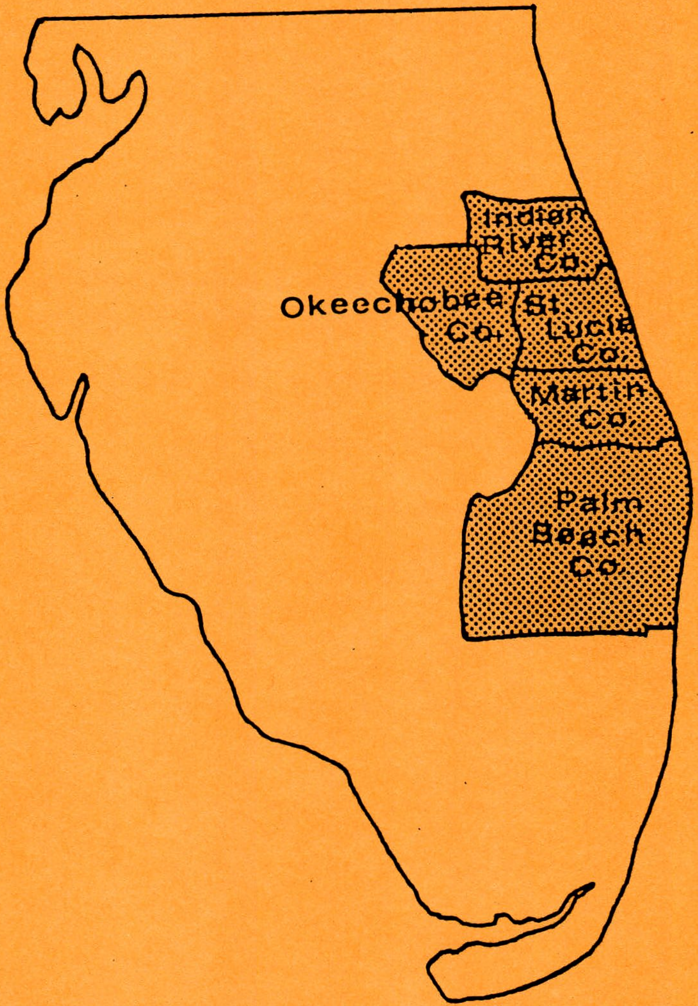
DISTRICT IX HEALTH PLAN

1984



LONG TERM CARE

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INTRODUCTION

"Long Term Care" is a generic term for the health care of people who have chronic ailments. Long Term Care is more than a nursing home, and not simply a health service; it is needed for more than just elderly populations, and it requires long term commitment of resources.

The definition used by the Department of Health and Human Services defines long term care as follows:

> *Long Term Care consists of those services designed to provide diagnostic, preventive, therapeutic, rehabilitative, supportive and maintenance services for individuals who have chronic physical and/or mental impairments in a variety of institutional and non-institutional health settings, including the home, with the goal of promoting the optimum level of physical, social and psychological functioning.*

The major goal of a Long Term Care System is to develop a "continuum of care"; that is, a wide range of services and facilities to provide any level of care needed by the individual. A continuum of care includes medical as well as social services, and ranges from total institutional care such as nursing homes and hospitals to less restrictive services or settings such as home health care, nutrition programs, etc.

The National Center for Health Statistics estimates that 81% of all persons over 65 have chronic conditions, 45.5% of those over 65 experience activity limitations due to these conditions and 39.4% are limited in major activities.[1] *In order to give each elderly individual the opportunity to seek an independent and rewarding life in old age, the Senate Special Committee on Aging has specified a threefold strategy:*

1. *To delay the onset of preventable disease in healthy adults;*
2. *To lengthen the period of functional independence in those elderly with chronic disease; and*
3. *To improve the quality of one's later life.*[2]

These strategies will be difficult to attain without greater coordination among all health and social service entities. However, the goals of continuity of care, of maximum level of functioning, and of living with the least possible restriction should add quality as well as quantity to life.[3]

ADULT DAY CARE

The United States Senate Special Committee on Aging has defined "day care" as a program of services provided under health leadership in an ambulatory care setting for adults who do not require 24-hour institutional care and yet, due to physical and/or mental impairment, are not capable of full-time independent living. Participants in the day care program are referred to the program by their attending physicians or by some other appropriate source such as an institutional discharge planning program or a welfare agency. The essential elements of a day care program are directed toward meeting the health maintenance and restorative needs of participants.[4] *Adult day care permits the family supporting the patient to work during the day, thus avoiding either institutionalizing the patient or reducing the family's income because one member of the family must stay at home to care for the elderly family member.*[5] *Adult day care provides the opportunity for the patients to engage in social activities, thereby enhancing the quality of life for functionally impaired individuals.*

RESPITE CARE

Respite services permit the family of an elderly person to take a break from caring for the elderly family member for a short period of time. There are two approaches to respite care; one in which the service is provided in the patient's home and the other in which the patient goes to an institution. In either case, a family would seek respite service for a specific period or for a vacation. Unlike adult day care, respite services operate 24 hours a day.[6]

HOME CARE FOR THE ELDERLY

Home Health care comprises a set of services that may be delivered in the home, singly or in tandem, to enable a disabled person to cope successfully with existing living arrangements. Home Health Agencies offer assessment of the patient, extended medical care, personal care and maintenance, counselling and linkages. Linkage services include information and referral, transportation, telephone reassurance and other services that enable the housebound to maintain linkage to the community and social network.[7]

The Palm Beach Regional Visiting Nurse Associaton, Inc. reported that, for February, 1984, of the 299 admissions, 251 were 65 and over.[8] *Across the nation, about 800,000 beneficiaries of Medicare received home health services in 1977. Of these, virtually all (96%) received nursing care services, one-third received home health aides, and 20% received physical therapy. Thirty percent of the home health visits were by home health aides. There were 21 visits per individual served. More than half (58%) of those served were 75 years of age and over.*[9]

ADULT FOSTER HOMES

Adult foster homes are not licensed by the State of Florida, but they receive a fire/safety inspection and a "home study". The DHRS Adult and Aging Program Office supervises placement and assigns a social worker to each home. The facility may have no more than three residents and, generally, provides a "family setting". Adult foster home residents must be ambulatory and able to carry out minimal personal functions because personal care is not necessarily provided. [10]

ADULT CONGREGATE LIVING FACILITIES

Adult Congregate Living Facilities (ACLFs) are privately-owned facilities, licensed by the State of Florida, which offer room, board and assistance with such personal needs as bathing, housekeeping and taking self-administered medications. ACLFs also help to arrange for transportation and conduct social and recreational services on behalf of residents. ACLFs do not provide medical care and must arrange for residents to obtain needed medical services. Costs vary considerably among ACLFs, but they are usually less than nursing home care. Residents usually stay on a month-to-month basis and are asked to sign an admission contract. [11]

ACLFs IN DISTRICT IX

County	*No. of ACLFs*	*No. of Beds*
Indian River	*3*	*82*
Martin	*2*	*22*
Okeechobee	*2*	*31*
Palm Beach	*29*	*902*
St. Lucie	*4*	*36*
TOTAL	*40*	*1,073*

NURSING HOMES

Nursing Homes in Florida are defined by regulation according to the type of care which they provide. A skilled nursing care home is defined as "a facility under the management of a licensed nursing home administrator, providing a full range of health and related services, including skilled and extended care, with or without an organized medical staff, having a registered nurse employed full time during eight hours, seven days a week and in charge of the nursing services and/or licensed practical nurses on duty at all other times and such additional personnel as may be required".[12]*Intermediate care nursing homes are essentially the same as skilled nursing care homes, except that the scope of services and the number of and hours of coverage by professional nurses required is less.*[13] *Many nursing homes have both skilled care beds and intermediate care beds.*

The most recent (1977) information from the National Center for Health Statistics *about the 1.1 million elderly in nursing homes describes them as primarily white, widowed, and with an average age of 83. Nineteen percent were aged 65 to 74, forty-one percent were 75 to 84, and forty percent were over 85 years of age. While five percent of the elderly are SNF residents at any one time, the probability of an SNF stay during the lifetime of all those over age 65 was more than twenty percent. The likelihood of such a placement rises to almost fifty percent for those over 85 years of age.*[14]

Of every 100 SNF residents, almost 40 came from their own homes and another 34 came from general hospitals. The rest were equally divided, with half referred by other nursing homes and the others coming, for the most part, from mental health facilities. While nursing home residents are thought of as long-term stayers, it has been estimated that about half of those admitted are discharged within three months. There seem to be two separate groups admitted to the SNF: the short-stay group, whose average length of stay is approximately 1.8 months, and a long-stay group who are residents for an average of 2.5 years.[15]

Nationally, the number of nursing home beds per 1,000 persons 65 and older is 54.[16] *In District IX, the projected 1986 number of beds per 1000 persons 65 and older was expected to be 19.7 but it will actually be 20.8 due to the status of nursing homes presently under construction. This is lower than the previous goal of 27 licensed long-term care beds for every 1000 persons aged 65 and older adopted in the 1981 Florida State Health Plan.*

An October, 1983 document released by the General Accounting Office, reveals that Florida's payment for the care of elderly persons in nursing homes was the lowest in the nation in 1980 even though it had the oldest population in the nation. They also reported that the need for nursing home care is not likely to decline, even in the view of increased community programs, given the overall projected increase in the number of those persons 75 and older and other factors such as declining informal supports. Moreover, the expansion of community programs and more careful screening of potential nursing home residents means that those who are admitted to nursing homes will have more intense, more costly care needs.[17]

THE ELDERLY POPULATION

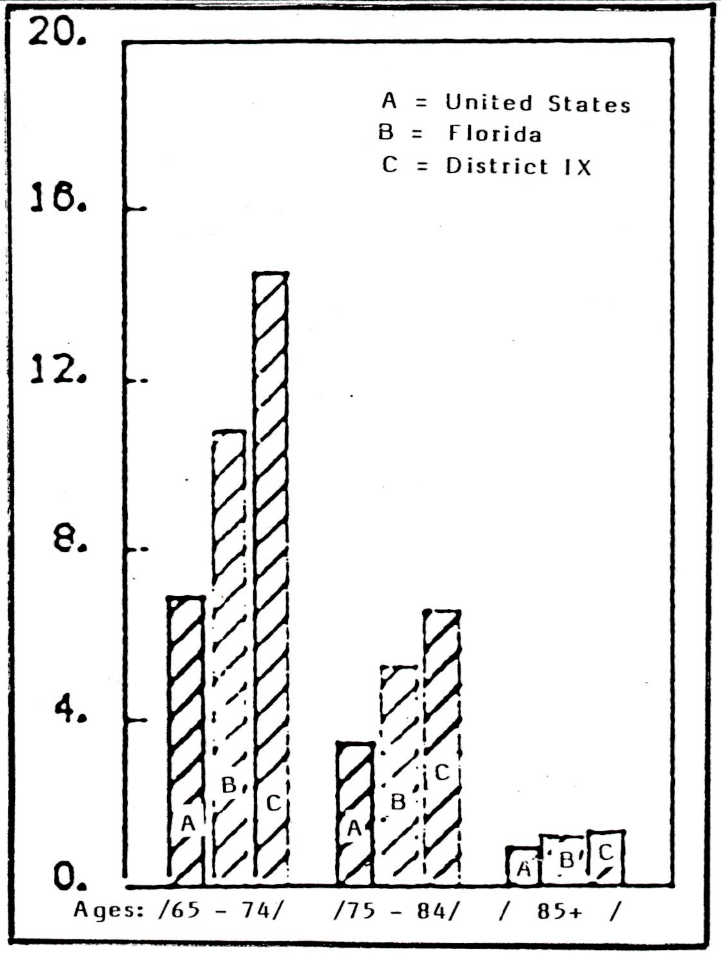
More Americans today live to older ages than ever before. In 1900, Americans who were 65 years old and over, made up four percent of the population. According to the 1980 Census, there are now 24 million persons over 65. This represents 11% of the population. Estimates indicate that, by the year 2000, persons 65 and older will number 50 million and comprise 17% of our population. In Florida, and in District IX particularly, the growth of the over 65 population has been explosive. Florida's population in 1970 was 6,791,418, of which 1,704,499 (17.5%) were over 65. For District IX, the 1970 population was 475,089 of which approximately 80,880 (17.0%) were over 65 years of age and in 1980, the population had increased to 808,168 of which 179,534 (22.2%) were over 65 years of age.

Nursing home use increases dramatically among those over the age of 75 and the proportion of the aged who are over 75 is increasing.

TABLE I

U.S., FLORIDA, AND DISTRICT IX
AGE DISTRIBUTION
(1980)

Percent of Total Population in:	65 - 74	75 - 84	85+	65+
United States	6.8	3.4	0.9	11.3
Florida	10.8	5.2	1.2	17.3
District IX	14.5	6.5	1.3	22.2



Population projections for the State of Florida also point to a shift toward the "older" elderly in the future.

TABLE II
FLORIDA POPULATION ESTIMATES 1980 - 1990
By Age Group

Age Group	*1980*	*% of 65+ Pop.*	*1985*	*% of 65+ Pop.*	*1990*	*% of 65+ Pop.*
65 - 74	*1,059,153*	*62.8*	*1,213,500*	*60.0*	*1,349,900*	*57.4*
75 - 84	*511,078*	*30.3*	*654,300*	*32.4*	*798,500*	*34.0*
85+	*117,342*	*6.9*	*154,400*	*7.6*	*203,000*	*8.6*
65+	*1,687,573*	*XXXX*	*2,022,200*	*XXXX*	*2,351,400*	*XXXX*

Source: University of Florida, Bureau of Economic and Business Research, Bulletin #64.

Population projections for District IX are only available for the 65 years and older category as a whole and these projections point to a tremendous growth for this age group in the near future.

TABLE III
DISTRICT IX ELDERLY POPULATION
1980, 1985 and 1990

	1980		*1985*		*1990*	
Area	*65+ Population*	*Percent of Total Population*	*65+ Population*	*Percent of Total Population*	*65+ Population*	*Percent of Total Population*
Indian River Co.	*12,180*	*20.3%*	*16,452*	*21.8%*	*21,019*	*23.3%*
Martin Co.	*15,654*	*24.5%*	*21,353*	*26.0%*	*27,481*	*27.6%*
Okeechobee Co.	*2,451*	*12.1%*	*3,499*	*14.1%*	*4,612*	*16.1%*
Palm Beach Co.	*134,452*	*23.3%*	*187,459*	*26.3%*	*247,023*	*29.3%*
St. Lucie Co.	*14,797*	*17.0%*	*20,847*	*18.2%*	*26,859*	*19.4%*
District IX	*179,534*	*22.2%*	*250,380*	*24.8%*	*328,643*	*27.4%*

Source: DHRS Population Projection 10/17/83.

Please Note: *Projection error for the District as a whole is not the same as for the individual counties.*

Palm Beach County has the largest number of elderly residents and is anticipated to have the largest rate of growth. By 1990, almost 30% of Palm Beach County residents will be 65 years of age and older. District IX's elderly growth is illustrated in the following table.

TABLE IV
GROWTH OF ELDERLY POPULATION IN DISTRICT IX SINCE 1980 CENSUS

	1985		*1990*	
Area	*Number*	*%*	*Number*	*%*
Indian River County	*4,272*	*35.1%*	*8,839*	*72.6%*
Martin County	*5,699*	*36.4%*	*11,827*	*75.6%*
Okeechobee County	*1,048*	*42.8%*	*2,161*	*88.2%*
Palm Beach County	*53,007*	*39.4%*	*112,571*	*83.7%*
St. Lucie County	*6,050*	*40.9%*	*12,062*	*81.5%*
District IX	*70,846*	*39.5%*	*149,109*	*83.1%*

Source: DHRS Population Projections, 10/17/83.

Please Note: *Projection error for the District as a whole is not the same as for the individual counties.*

By 1990, District IX is projected to experience an 83.1% increase over its 1980 elderly population. Palm Beach County and Martin County can expect that more than a quarter of their respective population will be 65 years or older by 1990.

How does this elderly growth boom translate into the need for nursing home beds? In a 1982 article by Dr. Laurence Branch and Dr. Alan Jette, they state, "Chronological age is the only demographic characteristic that displays a significant relationship to Long Term Care institutionalization. Living alone is the only social context variable that achieves a significant effect".[18] *A nursing home workgroup, set up under the auspices of DHRS, made the statement in a working paper that functionally impaired persons, lacking informal care givers and having low income, may be more likely to be placed in the nursing home than are persons with some other combination of factors.*[19]

According to the 1980 Census and the Center for Social Research in Aging at the University of Miami, some estimates of elderly under the poverty level and elderly lacking informal care givers can be derived.

TABLE V
PALM BEACH, MARTIN, ST. LUCIE, AND INDIAN RIVER COUNTIES AGE GROUP BY POVERTY LEVEL (1980 CENSUS)

	Age 65 -74		*Age 75+*	
Poverty Level	*Number*	*Percent*	*Number*	*Percent*
Under 87%	*6,950*	*6.0%*	*5,920*	*10.1%*
Total Below Poverty Level	*8,860*	*7.7%*	*7,460*	*12.7%*
100% - 149%	*10,820*	*9.4%*	*8,880*	*15.1%*
150% - 200%	*12,160*	*10.6%*	*7,020*	*12.0%*

Please Note: *Those elderly persons whose incomes are less than 87% of the poverty level are income-eligible for Federal Supplemental Social Security Income (SSI) assistance. Those elderly individuals whose incomes are under 147% of the poverty level in 1980 are income-eligible to participate in Federally funded Social Service Block Grant programs. The poverty threshold for a person age 65 or above who was living alone in 1979 was $3,479.*

TABLE VI
PALM BEACH, MARTIN, ST. LUCIE, AND INDIAN RIVER COUNTIES
AGE GROUP BY LIVING ARRANGEMENTS BY INCOME
(1980 CENSUS)

Mean Income Within Living Arrangement	Age 60 - 74	Age 75+
Living Alone:		
Number of Persons	29,120	17,740
Percent of Age Group	16.9%	29.2%
Mean Person Income	$10,179	$8,656
In Non-Family Households:		
Number of Persons	3,220	1,680
Percent of Age Group	1.9%	2.8%
Mean Person Income	$8,650	$11,467
In Homes for the Aged*:		
Number of Persons	760	2,060
Percent of Age Group	0.4%	3.4%
Mean Person Income	--	$2,247

*Includes Nursing, Convalescent and Rest Homes for the Aged and Dependent.

TABLE VII
PALM BEACH, MARTIN, ST. LUCIE, AND INDIAN RIVER COUNTIES
AGE, GENDER, AND INDICATORS OF SOCIAL SUPPORT
(1980 CENSUS)

	Age 60 - 74		Age 75+	
Indicators of Social Support	Number	Percent	Number	Percent
Married:				
Male	67,380	51.8%	20,240	64.2%
Female	62,660	48.2%	11,300	35.8%
Total Married	130,040	75.4%	31,540	51.8%
Moved into County in past Five Years:				
Male	32,400	50.4%	5,000	44.0%
Female	31,880	49.6%	6,360	56.0%
Total in-Migrants	64,280	36.4%	11,360	18.3%
Public Transportation Disability:				
Male	4,840	43.4%	4,020	32.5%
Female	6,320	56.6%	8,360	67.5%
Total with PTD	11,160	6.5%	12,380	20.3%

The above tables illustrate the situation in four of the five counties that comprise District IX. Many elderly do live alone, are close to the poverty level, have moved into the area within the last several years and do not have an informal support structure. When the elderly migrate from other areas of the country into District IX, they leave behind the family support structure and recent literature points to an indication that many elderly people are moving back to their original areas of residence.

How these variables translate directly into need for Long Term Care Services has not yet been determined. However, there is no doubt that the elderly population is growing rapidly in District IX and a corresponding growth in Long Term Care Services, both institutional and non-institutional, is needed.

NURSING HOME UTILIZATION

Current Capacity

As of April, 1984, there were 3,717 existing community nursing home beds and an additional 1,770 community nursing home beds approved for Certificate of Need in District IX. This brings the total number of existing/approved community nursing home beds to 5,487. Sheltered nursing home beds are those beds located in life care/-continuing care communities as defined in Chapter 651, Florida Statutes. In District IX, there are 280 existing sheltered nursing home beds and 90 approved for Certificate of Need. This brings the total number of existing/approved nursing home beds to 5,857. A total of thirty-six nursing homes are currently available for patient care and another seventeen are either under construction or will be shortly. Sheltered nursing home beds will be addressed in a separate section of this Plan.

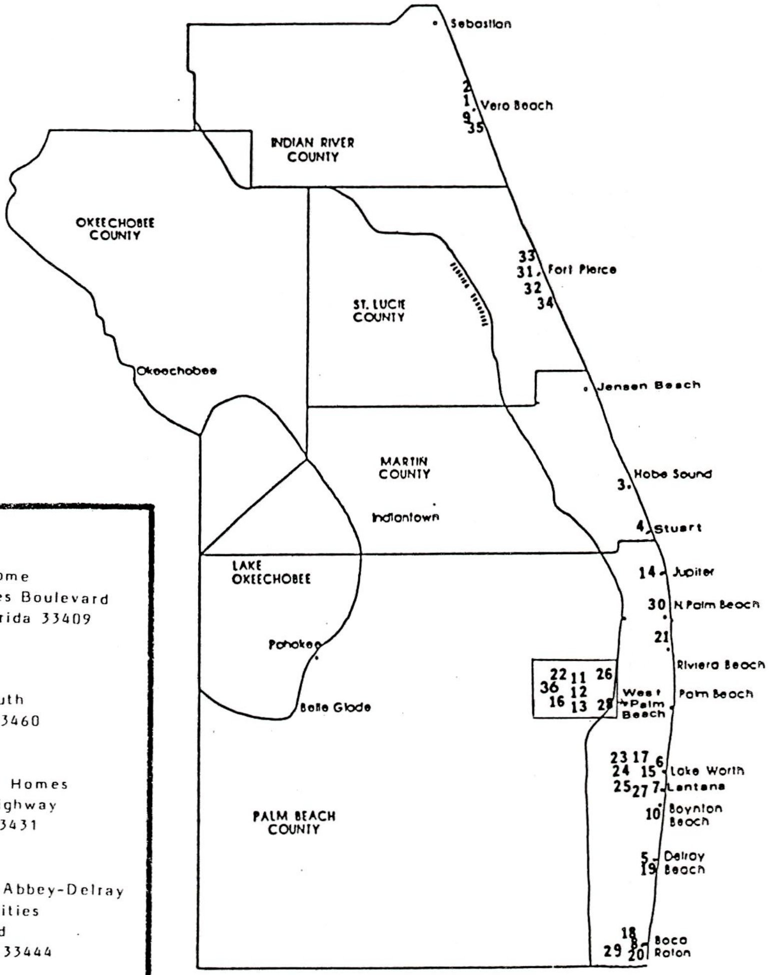
Martin and Indian River Counties, each, have a new 120 bed facility under construction. An existing nursing home in St. LucieCounty underwent a 60-bed expansion. Currently, there are no existing nursing homes in Okeechobee County but a 90-bed facility is under construction. A new 120-bed nursing home, the Joseph L. Morse Geriatric Center, opened in Palm Beach County in 1983. Palm Beach County has twelve homes approved for CON which represents 1,440 beds. This will give Palm Beach County a 54.4% increase in its total community nursing home bed count. Two nursing home CONs were voided during 1983 which means that there will be 240 less beds built in Palm Beach County in the near future.

Virtually all existing nursing homes are located in the coastal portions of the District, extending from Vero Beach in Indian River County to Boca Raton in southern Palm Beach County. This distribution of nursing homes follows the basic population patterns of the region.

TABLE VIII
DISTRICT IX
COMMUNITY NURSING HOME BEDS
AS OF APRIL, 1984

County	Nursing Home	Existing Beds		Subtotal	Approved Beds	Total
		Skilled	Intermediate			
INDIAN RIVER	Florida Baptist	24		24		24
	Mecca	26		26		26
	Royal Palm	72		72		72
	Vero Beach Care	110		110		110
	Health Care Mgmt.				120	120
	Subtotal	**232**		**232**	**120**	**352**
MARTIN	Hobe Sound Geriatric Village	120		120		120
	Stuart Convalescent	182		182		182
	Beverly Enterprises				120	120
	Subtotal	**302**		**302**	**120**	**422**
OKEECHOBEE	Okeechobee Health Care				90	90
	Subtotal				**90**	**90**
ST. LUCIE	Abbie Jean Russell	79		79		79
	Easter Manor	171		171		171
	Ft. Pierce Care	107		107		107
	Port St. Lucie Convalescent	180		180		180
	Subtotal	**537**		**537**		**537**
PALM BEACH	American Finnish	30	30	60		60
	Atlantis Convalescent	120		120		120
	Boca Raton Convales.	120		120		120
	Boulevard Manor	110		110		110
	Convales. Center of the Palm Beaches	99		99		99
	Convalescence Pavilion	120		120		120
	Crestview Manor	71		71		71
	Darcy Hall	220		220		220
	Eason's	99		99		99
	The Fountains	51		51		51
	Helen Wilkes	85		85		85
	King David	178	13	191		191
	Lakeside	97		97		97
	Lake View Manor	102		102		102
	Lake Worth Health Ctr.	162		162		162
	Lorde's Noreen McKeen	120		120		120
	Mason's	44		44		44
	Medicana	117		117		117
	Morse Geriatric Center	120		120		120
	Palm Beach Care	110	58	168		168
	Palm Beach County Home	90	91	181		181
	St. Andrews	60	60	120		120
	Whitehall-Boca	69		69		69
	Beverly Enterprises				120	120
	Florida Health Facility				120	120
	Ganot				120	120
	Hatton				120	120
	Health Care Assoc.				120	120
	Health Quest				120	120
	Henthrog				120	120
	Henthrog				120	120
	Manor Care				120	120
	Manor Care				120	120
	Nat'l. Med. Enterp.				120	120
	South. Senior Assoc.				120	120
	Subtotal	**2,394**	**252**	**2,646**	**1,440**	**4,086**
DISTRICT IX		**3,465**	**252**	**3,717**	**1,770**	**5,487**

DISTRICT IX
EXISTING NURSING HOMES
INCLUDING SHELTERED BEDS



KEY

1
Florida Baptist Retirement
Center Nursing Home
1006 Thirty-third Street
Vero Beach, Florida 32960

2
Mecca Convalescent Home
916 S.W. Highway #1
Vero Beach, Florida 32960

3
Hobe Sound Geriatric Village
9555 S.E. Federal Higwhay
Hobe Sound, Florida 33455

4
Stuart Convalescent Center
1500 Palm Beach Road
Stuart, Florida 33494

5
Abbey Delray South
1725 Homewood Boulevard
Delray Beach, Florida 33455

6
American Finnish Nursing Homo
1800 South Drive
Lake Worth, Florida 33461

7
Atlantis Convalescent Center
6026 Old Congress Road
Lantana, Florida 33462

8
Boca Raton Convalescent Center
755 Meadows Road
Boca Raton, Florida 33432

9
Royal Palm Convalescent Center
2180 Tenth Avenue
Vero Beach, Florida 32960

10
Boulevard Manor Nursing Home
2839 South Seacrest Boulevard
Boynton Beach, Florida 33435

11
Center at Palm Beach
1101 Fifty-fourth Street
West Palm Beach, Florida 33407

12
Convales cent Center of the
Palm Beaches
300 Fifteenth Street
West Palm Beach, Florida 33401

13
Convalescent Services of West
Palm Beach
2501 Australian Avenue
West Palm Beach, Florida 33407

14
The Convalescence Pavilion
1230 South Old Dixie Highway
Jupiter, Florida 33458

15
Crest Manor Nursing Home
504 Third Avenue South
Lake Worth, Florida 33460

16
Darcy Hall Nursing Home
2170 Palm Beach Lakes Boulevard
West Palm Beach, Florida 33409

17
Eason Nursing Home
1711 Sixth Avenue South
Lake Worth, Florida 33460

18
The Fountains Nursing Homes
3800 North Federal Highway
Boca Raton, Florida 33431

19
The Health Center at Abbey-Delray
Retirement Communities
2000 Lawson Boulevard
Delray Beach, Florida 33444

20
Whitehall Boca
7300 Del Prado Circle South
Boca Raton, Florida 33433

21
Helen Wilkes Nursing Home
750 Bayberry Drive
Lake Park, Florida 33403

22
Lake View Manor
208 Lakeview Avenue
West Palm Beach, Florida 33401

23
Lake Worth Health Center
2501 North A Street
Lake Worth, Florida 33460

24
Mason's Nursing Home
3185 Boutwell Road
LakeWorth, Florida 33461

25
Medicana Nursing Center
1710 Lucerne Avenue
Lake Worth, Florida 33460

26
Noreen McKeen Nursing Home
315 South Flagler
West Palm Beach, Florida 33401

27
Palm Beach Care Nursing Home
3599 Congress Avenue
Lake Worth, Florida 33460

28
Palm Beach County Home &
General Care Facility
1200 Forty-fifth Street
West Palm Beach, Florida 33407

29
St. Andrews Estates Medical
Center
6152 North Verde Trail
Boca Raton, Florida 33432

30
Waterford Nursing Home
420 U.S. Highway #1
North Palm Beach, Florida 33408

31
Abbiejean Russell Care Center
700 South 29 Street
Fort Pierce, Florida 33450

32
Easter Manor Nursing Home
611 South Thirteenth Street
Fort Pierce, Florida 33450

33
Fort Pierce Care Center
703 South Twenty-ninth Street
Fort Pierce, Florida 33450

34
Port St. Lucie Convalescent
Center
7300 Oleander Avenue
Port St. Lucie, Florida 33452

35
Vero Beach Care Center
3663 Fifteenth AVenue
Vero Beach, Florida 32960

36
Joseph L. Morse Geriatric Center
4847 Fred Gladstone Drive
West Palm Beach, Florida 33407

Historical

The District IX Health Council has continued the annual Nursing Home Utilization Survey that was established by the predecessor organization, the Health Planning Council, Inc. The results of the 1983 survey are tabulated and are included in the following section.

By incorporating some of the nursing home utilization data from previous years, a trend line was developed that depicts the historical utilization rates by county and for the District as a whole. Martin County, traditionally, has experienced the highest occupancy rates in its nursing homes. However, St. Lucie County has experienced a tremendous jump in its occupancy rates since 1982. Indian River County has also experienced a jump in its occupancy rates since 1982. Figure 1 illustrates the occupancy rates for the four counties and Figure 2 is an historical composite of the entire District.

Figure 1
HISTORICAL NURSING HOME UTILIZATION: 1980-1983
Martin, St. Lucie, Indian River and Palm Beach Counties

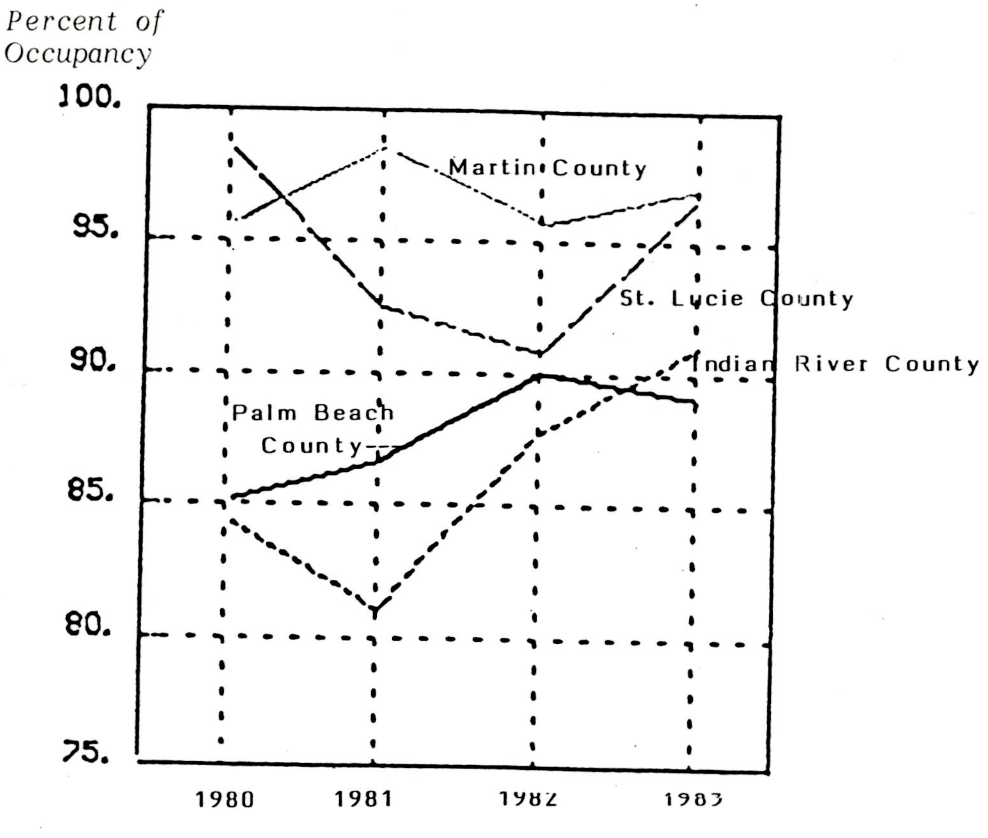
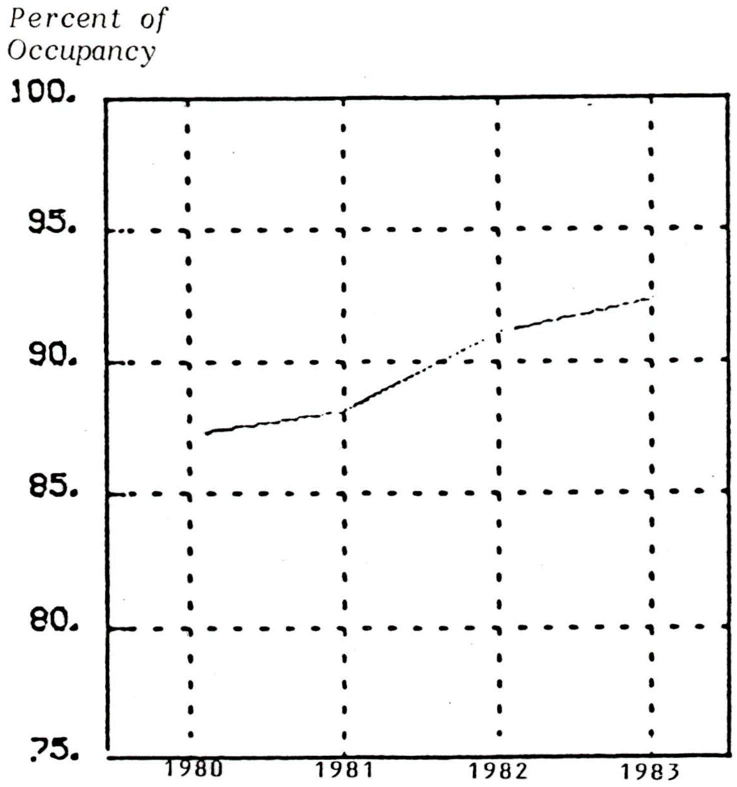


FIGURE 2
HISTORICAL NURSING HOME UTILIZATION: 1980 - 1983
DISTRICT IX



District IX has been experiencing a steady increase in nursing home patient days since 1980. With the exception of Martin County, the past couple of years have pointed to a continuing growth in patient days within each county. Figures 3 and 4 illustrate this increase.

FIGURE 3
PATIENT DAYS: 1980 - 1983
MARTIN, ST. LUCIE, AND INDIAN RIVER COUNTIES

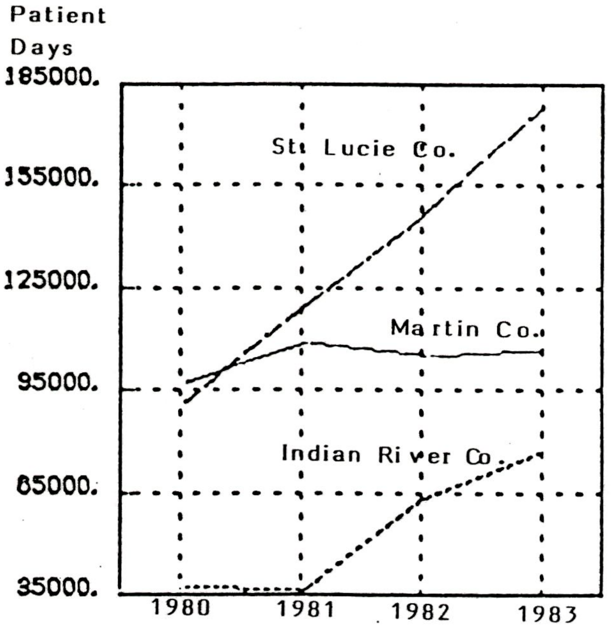
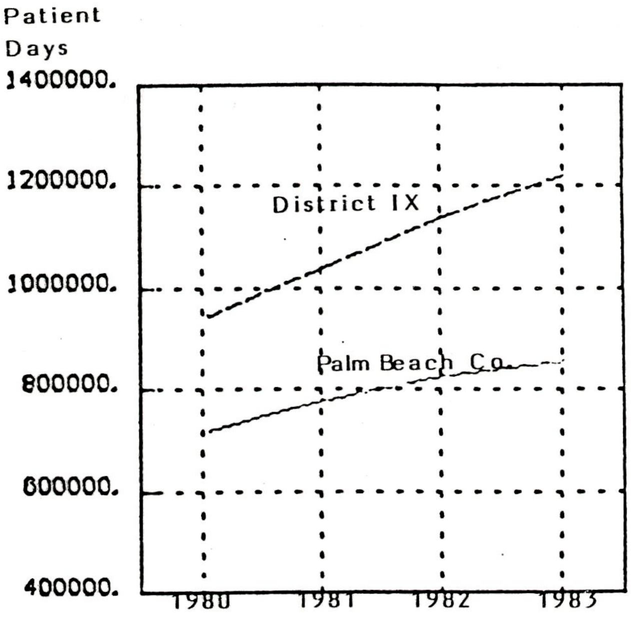


FIGURE 4
PATIENT DAYS: 1980 - 1983
PALM BEACH COUNTY AND DISTRICT IX



Since 1980, District IX has experienced a 26.3% increase in Medicaid patient days and a 40.3% increase in Medicare patient days. In 1980, the total number of all patient days was 943,175 while in 1983, the total was 1,222,430--an overall growth of 29.6%.

Indian River County has experienced the largest percent growth in Medicaid patient days (+234.0%) while Martin County actually declined in the number and percent of Medicaid patient days (-4.5%). Palm Beach County had the largest growth in numbers of Medicaid patient days (+54,784) followed by St. Lucie County (+46,548). Table IX illustrates the Medicaid patient days for 1980 and 1983.

Since 1980, St. Lucie County has experienced the greatest percent increase in Medicare patient days (+297.4%) and Palm Beach County had the lowest percent growth (+25.9%). However, Palm Beach County had the largest growth in numbers of Medicare patient days (+14,418) followed by St. Lucie County (+6,510). Table X illustrates the Medicare patient days for 1980 and 1983.

TABLE IX
MEDICAID PATIENT DAYS
Comparison: 1980 with 1983

	1980		1983			
AREA	# of Pt. Days	% Tot. Pt. Days	# of Pt.Days	% Tot. Pt. Days	# Change 1980--1983	% Change 1980--1983
Indian River Co.	8,371	22.3%	27,962	36.2%	+ 19,591	+234.0%
Martin Co.	60,745	62.9%	58,034	54.2%	- 2,711	- 4.5%
Palm Beach Co.	313,847	43.7%	368,631	42.9%	+ 54,784	+ 17.5%
St. Lucie Co.	66,275	73.6%	112,823	63.1%	+ 46,548	+ 70.2%
District IX	449,238	47.6%	567,450	46.4%	+118,212	+ 26.3%

TABLE X
MEDICARE PATIENT DAYS
Comparison: 1980 with 1983

	1980		1983			
AREA	# of Pt.Days	% Tot. Pt. Days	# of Pt. Days	% Tot. Pt. Days	# Change 1980--1983	% Change 1980--1983
Indian River Co.	2,675	7.1%	3,589	4.7%	+ 914	+ 34.2%
Martin Co.	1,398	1.4%	4,456	4.2%	+ 3,058	+218.7%
Palm Beach Co.	55,601	7.7%	70,019	8.1%	+14,418	+ 25.9%
St. Lucie Co.	2,189	3.6%	8,699	4.9%	+ 6,510	+297.4%
District IX	61,863	6.6%	86,763	7.1%	+24,900	+ 40.3%

1983 Utilization

In 1983, the 33 community nursing homes in District IX collectively reflected an annual licensed bed occupancy rate of 92.4%. Sheltered nursing home beds are not included in this section but it is interesting to note that one of the four life care/continuing care nursing homes is included in the following inventory due to the way in which the Department of Health and Rehabilitative Services reports the existing inventory.

In 1983, the District IX community nursing homes served a total of 1,222,430 patient days. The following figure indicates what percentage of the total patient days each county served in 1983.

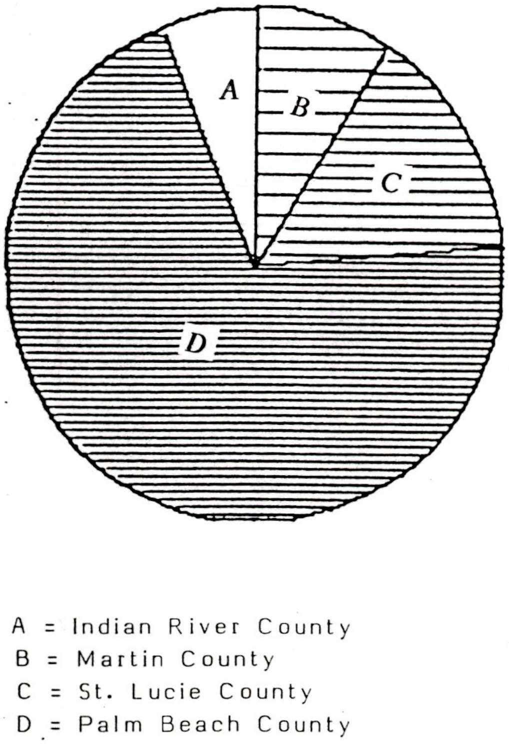


Figure 5
1983 PATIENT DAYS
DISTRICT IX
PROPORTIONAL AMOUNTS BY COUNTY

The following graph illustrates the 1983 licensed bed occupancy rates for the District and for the individual counties.

Figure 6
1983 Licensed Bed Occupancy Rates

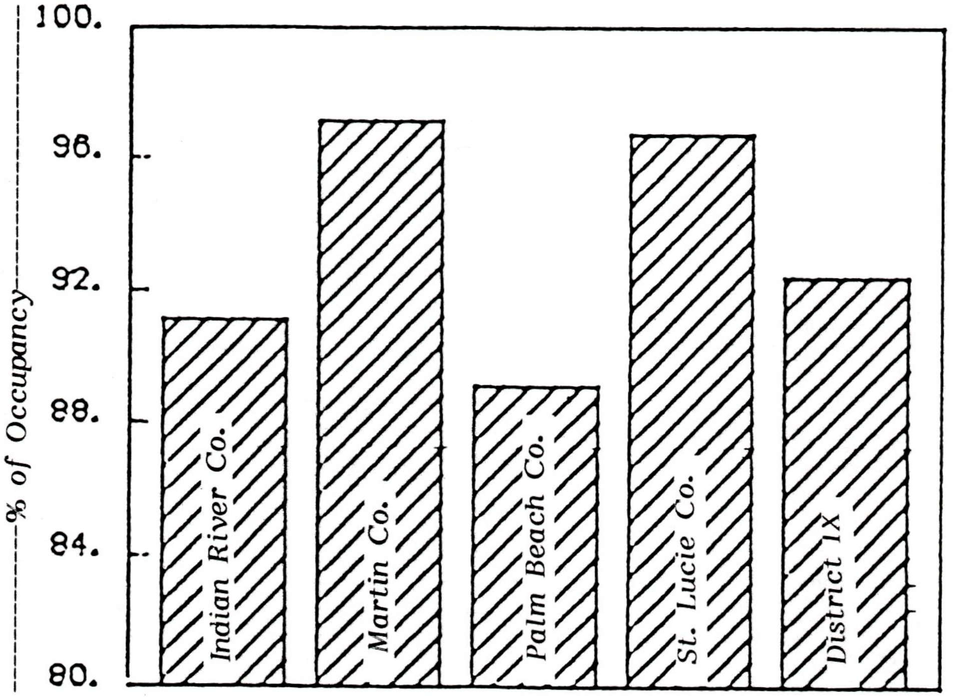


Table XI indicates the individual nursing homes by county with subtotals as well as a total for the District. The number of licensed beds, available beds (licensed beds which are staffed for patient use--excludes any beds which may be temporarily closed due to remodeling, staffing shortages, etc.), total patient days and licensed bed occupancy rates are included. Please note that all patient days are incorporated into these rates, including paid reservation days, since an unoccupied bed for which revenue is received renders that bed unavailable for someone else to use.

TABLE XI
NURSING HOME UTILIZATION

XI-A INDIAN RIVER COUNTY

Name of Nursing Home	Number of Beds: Licensed	Number of Beds: Available	Total Patient Days	Occupancy Rate (%) (Lic. Beds)
Florida Baptist	24	24	8,038	91.7%
Mecca - Convalescent Home of Mecca Two	26	26	9,428	99.3%
Royal Palm Convalescent	72	72	20,986	79.9%
Vero Beach Care Center	110	110	38,689	96.4%
County Subtotal	**232**	**232**	**77,141**	**91.1%**

XI-B MARTIN COUNTY

Name of Nursing Home	Number of Beds: Licensed	Number of Beds: Available	Total Patient Days	Occupancy Rate (%) (Lic. Beds)
Hobe Sound Geriatric Village	120	120	42,366	96.7%
Stuart Convalescent	182	182	64,636	97.3%
County Subtotal	**302**	**302**	**107,002**	**97.1%**

XI-C ST. LUCIE COUNTY

Name of Nursing Home	Number of Beds: Licensed	Number of Beds: Available	Total Patient Days	Occupancy Rate (%) (Lic. Beds)
Abbiejean Russell Care Ctr.	79	79	28,672	99.4%
Easter Manor	171	171	61,959	99.3%
Ft. Pierce Care Center	107	107	37,758	96.7%
Pt. St. Lucie Convalescent Center	180*	150	50,476	92.2%
County Subtotal	**537**	**507**	**178,865**	**96.7%**

*As of June, 1983.

XI-D PALM BEACH COUNTY

Name of Nursing Home	Number of Beds: Licensed	Number of Beds: Available	Total Patient Days	Occupancy Rate (%) (Lic. Beds)
American-Finnish	60	60	21,919	99.9%
Atlantis Convalescent	120	120	43,800	100.0%
Boca Raton Convalescent	120	120	38,314	87.5%
Boulevard Manor	110	110	39,327	98.0%
Convalescent Center of the Palm Beaches	99	99	30,284	83.8%
Convalescent Pavilion	120	120	40,402	92.2%
Crest Manor	71	71	25,209	97.3%
Darcy Hall	220	203	69,337	86.3%
Eason	99	99	34,334	95.0%
The Fountains	51	51	18,131	97.4%
Helen Wilkes	85	81	26,725	86.1%
King David Center* (Center at P.B.)	191	191	65,810	94.4%
Lakeside Health Center	97	97	32,579	92.0%
Lakeview Manor	102	102	36,327	97.6%
Lake Worth Health Center*	162	162	58,643	99.2%
Lorde's Noreen McKeen	120	120	42,048	96.0%
Mason's	44	44	14,303	89.1%
Medicana	117	117	42,528	99.6%
Morse Geriatric Center**	120	120	16,207	75.9%
Palm Beach Care	168	168	60,706	99.0%
Palm Beach County Home and General Care Facility	181	181	53,280	80.6%
St. Andrews	120	120	31,499	71.9%
Whitehall-Boca	69	69	17,710	70.3%
County Subtotal	**2,646**	**2,625**	**859,422**	**89.1%**

*1983 data not reported. Therefore, 1982 data has been substituted.
**Opened July 7, 1983.

XI-E DISTRICT IX

County Subtotal	Number of Beds		Total Patient Days	Occupancy Rate (%) (Lic. Beds)
	Licensed	Available		
Indian River	232	232	77,141	91.1%
Martin	302	302	107,002	97.1%
Okeechobee	---BEDS APPROVED BUT NOT OPEN------			
Palm Beach	2,646	2,625	859,422	89.1%
St. Lucie	537	507	178,865	96.7%
Total District IX	**3,717**	**3,666**	**1,222,430**	**92.4%**

Payment Source

In 1983, 46.4% of all patient days in District IX were Medicaid, 7.1% were Medicare and 46.5% were in the private pay and other category. The other category consists of paid reservation days and veterans administration days.

The following figures illustrate payment source by county and for the entire District. Table XII lists the individual nursing homes by payment source, with a summary for the counties and the District.

Figure 7: 1983 UTILIZATION BY PAYER SOURCE

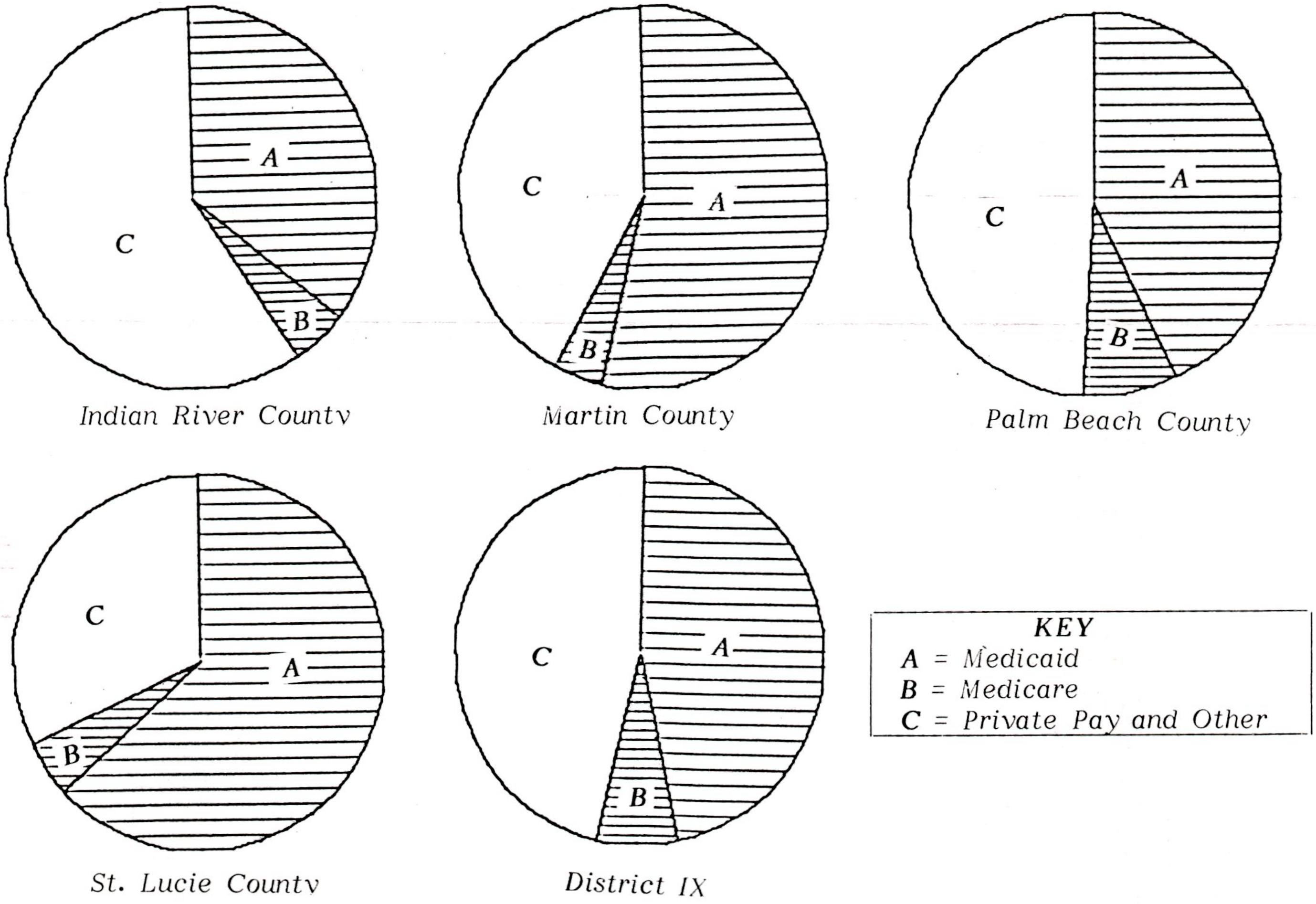


TABLE XII
1983--NURSING HOMES BY PAYER SOURCE

XII-A INDIAN RIVER COUNTY

Name of Nursing Home	Medicaid		Medicare		Private Pay & Other	
	# of Pt. Days	% of Total Pt. Days	# of Pt. Days	% of Total Pt. Days	# of Pt. Days	% of Total Pt. Days
Florida Baptist	-0-	--	-0-	--	8,034	100.0%
Mecca - Convalescent Home of Mecca Two	7,172	76.1%	552	5.9%	1,704	18.1%
Royal Palm Convalescent	-0-	--	341	1.6%	20,645	98.4%
Vero Beach Care Center	20,790	53.7%	2,696	7.0%	15,203	39.3%
County Subtotal	**27,962**	**36.2%**	**3,589**	**4.7%**	**45,586**	**59.1%**

XII-B MARTIN COUNTY

Name of Nursing Home	Medicaid		Medicare		Private Pay & Other	
	# of Pt. Days	% of Total Pt. Days	# of Pt. Days	% of Total Pt. Days	# of Pt. Days	% of Total Pt. Days
Hobe Sound Geriatric Village	22,018	52.0%	1,494	3.5%	18,854	44.5%
Stuart Convalescent	36,016	55.7%	2,962	4.6%	25,658	39.7%
County Subtotal	**58,034**	**54.2%**	**4,456**	**4.2%**	**44,512**	**41.6%**

XII-C ST. LUCIE COUNTY

Name of Nursing Home	Medicaid		Medicare		Private Pay & Other	
	# of Pt. Days	% of Total Pt. Days	# of Pt. Days	% of Total Pt. Days	# of Pt. Days	% of Total Pt. Days
Abbiejean Russel Care Center	21,631	75.4%	-0-	--	7,041	24.6%
Easter Manor	43,173	69.7%	2,210	3.6%	16,576	26.8%
Ft. Pierce Care Center	25,415	67.3%	2,348	6.2%	9,995	26.5%
Pt. St. Lucie Convalescent Center	22,604	44.8%	4,141	8.2%	23,731	47.0%
County Subtotal	**112,823**	**63.1%**	**8,699**	**4.9%**	**57,343**	**32.1%**

XII-D PALM BEACH COUNTY

Name of Nursing Home	Medicaid		Medicare		Private Pay & Other	
	# of Pt. Days	% of Total Pt. Days	# of Pt. Days	% of Total Pt. Days	# of Pt. Days	% of Total Pt. Days
American-Finnish	8,215	37.5%	-0-	--	13,704	62.5%
Atlantis Convalescent	14,600	33.3%	5,475	12.5%	23,725	54.2%
Boca Raton Convalescent	4,857	12.7%	6,993	18.3%	26,464	69.1%
Boulevard Manor	4,595	11.7%	6,813	17.3%	27,919	71.0%
Convalescent Center of the Palm Beaches	5,127	16.9%	9,078	30.0%	16,079	53.1%
Convalescent Pavillion	7,523	18.6%	5,944	14.7%	26,935	66.7%
Crest Manor	17,114	67.9%	522	2.1%	7,573	30.0%
Darcy Hall	18,993	27.4%	-0-	--	50,344	72.6%
Eason	12,793	37.3%	3,188	9.3%	18,353	53.5%
The Fountains	418	2.3%	1,472	8.1%	16,241	89.6%
Helen Wilkes	699	2.6%	-0-	--	26,026	97.4%
King David Center* (Center at P.B.)	49,465	75.2%	5,210	7.9%	11,135	16.9%
Lakeside Health Center	14,543	44.6%	5,568	17.1%	12,468	38.3%
Lakeview Manor	34,487	94.9%	-0-	--	1,840	5.1%
Lake Worth Health Center*	46,561	79.4%	2,715	4.6%	9,367	16.0%
Lorde's Noreen McKeen	7,300	17.4%	4,745	11.3%	30,003	71.4%
Mason's	103	0.7%	3,487	24.4%	10,713	74.9%
Medicana	6,497	15.3%	4,689	11.0%	31,312	73.7%
Morse Geriatric Center **	6,954	42.9%	-0-	--	9,253	57.1%
Palm Beach Care	54,385	89.6%	-0-	--	6,321	10.4%
Palm Beach County Home & General Care Facility	53,280	100.0%	-0-	--	-0-	--
St. Andrews	122	0.4%	4,120	13.1%	27,257	86.5%
Whitehall-Boca	-0-	--	-0-	--	17,710	70.3%
County Subtotal	**368,631**	**42.9%**	**70,019**	**8.1%**	**420,772**	**49.0%**

*1983 data not reported. Therefore, 1982 data has been substituted.
**Opened July 7, 1983

XII-E DISTRICT IX						
	Medicaid		Medicare		Private Pay & Other	
County Subtotal	# of Pt. Days	% of Total Pt. Days	# of Pt. Days	% of Total Pt. Days	# of Pt. Days	% of Total Pt. Days
Indian River	27,962	36.2%	3,589	4.7%	45,586	59.1%
Martin	58,034	54.2%	4,456	4.2%	44,512	41.6%
Okeechobee	--------------	-BEDS APPR	OVED BUT	NOT OPEN--	--------------	--------------
Palm Beach	368,631	42.9%	70,019	8.1%	420,772	49.0%
St. Lucie	112,823	63.1%	8,699	4.9%	57,343	32.1%
Total District IX	**567,450**	**46.4%**	**86,763**	**7.1%**	**568,213**	**46.5%**

Please note: Numbers may not total to 100% due to rounding error.

Under the category of "Private Pay & Other", paid reservation days is an important issue. To the best of our knowledge, the existing nursing homes do not report these days to the State. If revenue is received for an unoccupied bed, thereby rendering the bed unavailable, then reality dictates that paid reservation days have some effect upon the community nursing home bed supply. In 1983, the homes shown in Table XIII were affected by paid reservation days.

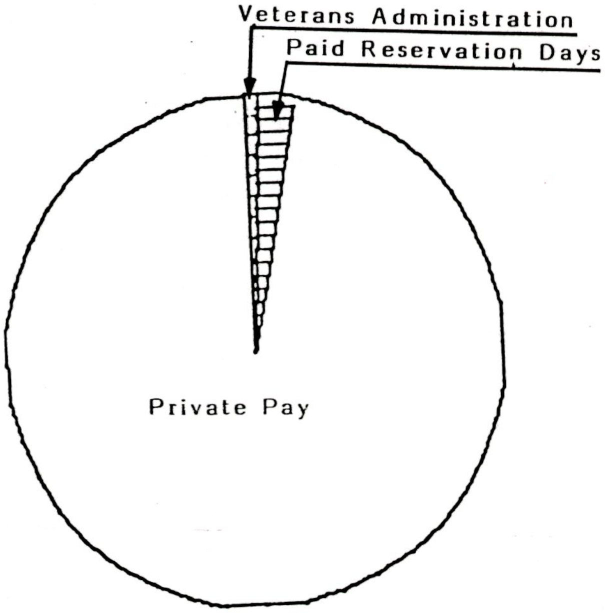
TABLE XIII
NURSING HOMES AFFECTED BY
PAID RESERVATION DAYS

Nursing Home by County	Number of Days	Percent of Total Patient Days
Indian River County		
Vero Beach Care Center	488	1.3%
Martin County		
Hobe Sound Geriatric Village	302	0.7%
Stuart Convalescent Center	118	0.2%
St. Lucie County		
Abbiejean Russell	527	1.8%
Easter Manor	519	0.8%
Ft. Pierce Care Ctr.	85	0.2%
Pt. St. Lucie Convalescent Center	47	0.1%
Palm Beach County		
American-Finnish	292	1.3%
Atlantis Convalescent Center	730	1.7%
Boca Raton Convalescent	246	0.6%
Boulevard Manor	1,776	4.5%
The Convalescence Pavillion	75	0.2%
Crest Manor	599	2.4%
Eason	647	1.9%
The Fountains	3,649	20.1%
Helen Wilkes	148	0.6%
Lakeside Health Center	959	2.9%
Lakeview Manor	573	1.6%
Mason's	116	0.8%
Medicana	1,234	2.9%
Morse Geriatric Center	409	2.5%
St. Andrews	479	1.5%
District IX Total	**14,018**	**1.1%**

In essence, the analysis of paid reservation days shows that in 1983, forty beds in District IX were unavailable. Therefore, paid reservation days do have an impact upon the nursing home bed supply and they should be monitored accordingly, both by this Council and by the State.

Veterans Administration patient days account for 4% (4,782) of all 1983 patient days in District IX. Figure 8 illustrates the three components of the "Private Pay & Other" category.

Figure 8
District IX 1983 Utilization by Payer Source
"Private Pay & Other" Category



LIFE CARE/CONTINUING CARE NURSING HOMES

The concept of a life care or continuing care community is based upon the establishment of a residential environment for older persons that, on one campus, provides housing, comprehensive support services, and a full range of nursing care services. Chapter 651 of Florida Statutes, Section 2 defines the concept as follows:

> *"Continuing care" or "care" means furnishing pursuant to an agreement shelter, food, and either nursing care or personal services as defined in s.400. 402(8), whether such nursing care or personal services are provided in the facility or in another setting designated by the agreement for continuing care, to an individual not related by consanguinity or affinity to the provider furnishing such care, upon payment of an entrance fee. Other personal services provided shall be designated in the continuing care agreement. Agreements to provide continuing care include agreements to provide care for any duration, including agreements that are terminable by either party.*

If the nursing home is open only to residents of the life care community, then the beds are considered sheltered nursing home beds. Otherwise, these beds are considered part of the District's community nursing home beds, and are available to anyone needing placement.

In District IX, all of the existing and approved continuing care nursing homes are located in Palm Beach County. The inventory is shown in Table XIV.

TABLE XIV
INVENTORY OF LIFE CARE/CONTINUING CARE NURSING HOME BEDS

	Existing Beds			Approved	
Facility	Skilled	Intermediate	Subtotal	Beds	Total
Abbey Delray South	60	--	60	--	60
Health Center of Abbey Delray	100	--	100	--	100
Waterford Health Care Center	60	--	60	--	60
St. Andrews Medical Center*	60	60	120	--	120
Harbour's Edge	--	--	--	30	30
Edgewater Pointe Estates	--	--	--	60	60
TOTAL	280	60	340	90	430

**The HRS inventory listing does not count this facility as a life care nursing home.*

The occupancy rates within these facilities appear to be lower than the surrounding nursing homes. In 1983, the licensed bed occupancy rate for all of the continuing care nursing home beds was 81.3%. The majority of the patients were either life care residents or private pay patients. Medicaid and Medicare patient days combined were 19.8% of the total patient days in 1983. Paid reservation days were 2.3% of the total patient days.

TABLE XV
LIFE CARE CONTINUING CARE NURSING HOME UTILIZATION

Facility	# of Beds		Total Patient Days*	Occupancy Rate (Lic. Beds)*	Medicaid		Medicare		Private Pay		Paid Reservation[a]		Life Care Residents	
	Lic.	Avail.			Patient Days	% of Total	Patient Days	% of Total	Patient Days	% of Total	Patient Days	% of Total	Patient Days	% of Total
Abbey Delray South	60	60	19,077	87.1%	105	0.6%	4,266	22.4%	14,589	76.5%	117	0.6%	NR	--
Health Center at Abbey Delray	100	100	32,735	89.7%	1,697	5.2%	3,915	12.0%	13,687	41.8%	1,683	5.1%	11,753	35.9%
Waterford Health Care Ctr.	60	60	17,536	80.1%	892	5.1%	4,862	27.7%	7,511	42.8%	78	0.4%	4,193	23.9%
St. Andrews Medical Ctr.[b]	120	120	31,499	71.9%	122	0.4%	4,120	13.1%	7,083	22.5%	479	1.5%	19,695	62.5%
District IX Total	**340**	**340**	**100,847**	**81.3%**	**2,816**	**2.8%**	**17,163**	**17.0%**	**42,870**	**42.5%**	**2,357**	**2.3%**	**35,641**	**43.6%**

*Including PaidReservation Days.

[a] Paid Reservation Days include endowed bed days and private room conversions.

[b] The HRS inventory listing does not count this facility as a life care nursing home.

Physical Status

Last year, it was reported that the Lakeview Manor Nursing Home in West Palm Beach is in desperate need of replacement or major renovation. Presently, the owners of the facility have applied for an expedited review of their Certificate of Need application to relocate the home. The application points to life/safety code violations that are extensive. This home is located in downtown West Palm Beach and is crucial in meeting the needs of the elderly. In 1983, 94.9% of all their patient days was Medicaid.

Service Areas

Palm Beach County, Martin County, St. Lucie County, Indian River County, and Okeechobee County will each be considered a subdistrict in accordance with the Department of HRS subdistricting protocol. However, the western portion of Palm Beach County around Lake Okeechobee, should not be considered in competition with the coastal portion of the County. This very rural region has far different needs than the rest of Palm Beach County. This agricultural region has severe accessibility problems to the eastern portion of the County due to poor roadways, the lack of any east-west transportation systems, and a distance of over 40 miles (official road map mileage from West Palm Beach to Belle Glade is 43 miles). The subdistricting protocol does not allow the western area to become its own subdistrict and, therefore, has been included in the Palm Beach County subdistrict.

Major Issues To Be Addressed

The onset of the Medicare prospective reimbursement rates for hospital inpatients, based upon Diagnostic Related Groups (DRGs), is expected to have an impact upon nursing homes and other long term care services. Under the DRG formula, a given diagnosis is allowed a specific length of stay (LOS) and any extension beyond the allotted time will not be reimbursed by Medicare. Several nursing home administrators have expressed concern over the effect that the DRG policy will have on homes relative to the ability of a nursing home to provide for increased numbers of heavy care patients within the constraints of limited resources.

In District IX, the high occupancy rates and the small supply of nursing home beds will be problematic if many new, heavy care patients are released from area hospitals and cannot return home. This situation must be watched closely by both the State and this Council.

Length of stay within the nursing homes could possibly become another major issue. As discussed in an earlier section, there appear to be two types of patients--the short stay patient and the long term stay patient. Many of the homes in District IX do not have the intensive rehabilitation services that a short stay patient would need. And if the Stuart Convalescent Center is typical of nursing homes in District IX, length of stay is a major issue. On March 21, 1984, a tabulation was taken of all 181 patients residing in the facility and, on that data, the average length of stay for all patients was 2 years and 20 days. Of those 181 patients, 35% had been in residence longer than the average, 21% had been in the facility longer than 3 years, and 16% had been in residence longer than four *years. If so many nursing home patients are long term, this definitely impacts upon the availability of existing nursing home beds for the growing elderly population in District IX.*

There are also those patients that are in need of care who are not able to find appropriate care. These patients include the mentally ill, those under 16 years of age with major trauma-type injuries and the Medicaid "gap" people. In 1974, the National Institute of Mental Health estimated that approximately 58% of nursing home residents suffer from chronic mental illness. A 1982 report by the General Accounting Office stated that, ".....although nursing homes have become frequent health care providers for the elderly with mental problems, the treatment provided remains almost exclusively focused on physical illness."[20] *Many mentally ill patients are housed in Adult Congregate Living Facilities in District IX and this presents problems for the frail elderly who live in these facilities.*

Patients under 16 years of age with major trauma injuries; i.e., spinal and head trauma, cannot be cared for in area nursing homes and are forced to reside in Adult Congregate Living Facilities even though they may not be appropriately placed. There are no long term rehabilitation facilities in District IX to care for these individuals. And those patients who do not qualify for Medicaid, do not have private insurance, and are impoverished, find that placement in a nursing home is nearly impossible. These issues also require greater investigation.

A step in the right direction would entail setting up "campuses" of long term care services whereby all long term care services are available in one place. Group homes similar to the Intermediate Care Facilities for the Mentally Retarded could be one approach, along with more care intensive and less care intensive services. The continuum of care concept will work only if access to all long term care services is a reality.

PROGRAM GOALS

The number of nursing home beds in District IX should be no greater than 27 beds per 1000 individuals age 65 and over as modified by the State of Florida Department of Health and Rehabilitative Services bed need methodology and demonstrated local need. Local need within established subdistricts should be based upon the growth of the 75 and over population and accessibility problems due to population growth patterns.

The average annual occupancy rate for all nursing homes in District IX should be equal to or greater than 90% within two (2) years of opening.

All nursing homes in District IX should participate on an equitable basis in the Florida Medicaid program.

A quality long term care system should exist in District IX to include nursing home care, adult congregate living facilities, adult day care, respite care, adult foster homes and home care in sufficient quantity and mix to meet the needs of the elderly population in an effective and efficient manner.

The long term care system should recognize the need for facilities that provide ethnic type services including special dietary requirements and bilingual personnel.

Long term care services should include provisions for mental health patients so that they are appropriately placed in the proper settings.

Nursing homes should be encouraged to provide a continuum of long term care services so that coordination between differing levels of services can be achieved to the patient's benefit.

Long term care services should include more short term type rehabilitation services for those patients who require intensive rehabilitation below the level of an acute care hospital. These patients generally stay in a nursing home less than three months.

RECOMMENDATIONS BY PRIORITY RANKING

In addition to the Nursing Home Bed Allocation Methodology (Florida Administrative Code, Chapter 10-5, 11(21)(22), the District IX Health Council has established the following policies and priorities which should be used concurrently in planning nursing home bed need and allocation.

Priority I

A. ***The following subdistricts are identified for the purpose of allocating nursing home beds:***
   - *a. Indian River County*
   - *b. Martin County*
   - *c. Okeechobee County*
   - *d. Palm Beach County*
   - *e. St. Lucie County*

B. ***New applications in the Glades Area should not be considered as competing applications with the subdistrict of Palm Beach County. Consideration should be given to patient flow patterns from neighboring Hendry County into the Glades Area.***

Rationale

The Glades Area is defined as that portion of western Palm Beach County comprising population zone 099001. Currently, this area is included with the subdistrict of Palm Beach County because it does not qualify as a subdistrict of its own. However, it would not be practical or fair to compare the very rural Glades region with the highly developed urban coastal regions. The poor east-west highways and basic lack of transportation prohibits residents of the Glades Area from utilizing services on the coast. Hence, their special needs should be addressed separately and distinctly from Palm Beach County. Furthermore, because Hendry County and western Palm Beach County are adjacent and are both very rural and somewhat isolated from the coastal areas, their needs should be considered concurrently. Many residents in both Hendry and the Glades visit the other for a variety of services including health care.

Priority II

A. ***Free standing nursing homes should have a minimum of 60 beds in rural subdistricts and 120 beds in urban subdistricts.***

Rationale:

Nursing homes must be of significant size in order to offer a complete range of quality services given the lower reimbursement received from the Medicaid/-Welfare patients residing in the home. Though 120 beds is considered an appropriate size due to economies of scale, rural subdistricts should not be penalized if the population base does not warrant a 120 bed home.

B. Priority shall be given to those existing homes with less than 120 beds to add on beds so that the total capacity will be no greater than 120 beds. The applicant should be able to demonstrate a licensed bed occupancy rate within the existing home greater than 90% for the prior calendar year.

Rationale:

In determining the need for additional nursing home beds, consideration should be given to economies of scale and expansion of existing facilities prior to construction of new homes. An existing home should reach an appropriate utilization threshold before new beds are added. Sufficient home size is paramount in providing a full range of quality patient services.

Priority III

A. All new nursing homes and expansions to existing facilities must agree that a minimum of 30% of its patient days will be Medicaid if such patients are available within the subdistrict.

Rationale:

Nursing homes are community resources and should be available to everyone. There must be an equitable participation in the Medicaid program.

B. The State, as well as the local health councils, should monitor the Medicaid reimbursement structure for nursing homes to assure that the nursing homes are sufficiently compensated for their costs.

Rationale:

Historically, nursing homes in District IX have had severe problems with receiving adequate compensation for the Medicaid patients they serve. A 1979 study by the Health Planning Council, Inc. indicated that there was a $3 Million differential between the actual cost and the amount of Medicaid reimbursement for nursing homes in District IX. If CON policies exist that require a facility to accept a minimum number of Medicaid patients, it is essential that there is sufficient reimbursement.

Priority IV

Priority shall be given to applicants who demonstrate that they will provide a range of long term care services such as adult day care and respite care programs for the surrounding community.

Ratonale:

Nursing homes should be encouraged to provide a continuum of long term care services so that coordination between differing levels of services can be achieved to the patient/client's benefit.

Priority V

Priority shall be given to applicants who demonstrate the following:

1. ***documented history of providing good resident care***
2. ***staffing ratios, particularly for registered nurses and aides, that exceed minimum requirements***
3. ***provisions for the treatment of residents with mental health problems***
4. ***the inclusion of intensive rehabilitation services for those short stay patients requiring rehabilitation below the level of an acute care hospital.***

Rationale:

Quality nursing home care is essential for the well being of residents. A home that will provide higher staffing ratios than is required by licensure criteria, should add to the quality of care that a patient will receive in the home. Patients with mental health problems and "short stay" patients need to have specialized services available to them in the home.

Priority VI

Priority shall be given to those applicants who can demonstrate a distinct patient population that is currently not being served within the subdistrict. Ethnic-type services including special dietary requirements and bilingual personnel shall be considered in review of an application.

Rationale:

Some residents require special services (a kosher kitchen, for example) that are not available in most nursing homes. These special needs should be recognized in the Certificate of Need process.

Priority VII

Paid reservation days must be considered when bed need calculations are made.

Rationale

Many nursing homes that have paid reservation days reflect occupancy rates which are lower than they should be. Because these prepaid days are not always counted in the total number of patient days, the utilization rates must be scrutinized carefully to determine if this has, indeed, occurred. If the paid reservation days are not used in occupancy rate calculations, a lower occupancy rate would result in a lower projected bed need.

FOOTNOTES

1. *American Health Planning Association. A Guide for Planning Long Term Care Health Services for the Elderly. Washington, D.C.: AHPA, 1982; p.3.*
2. *Brody, Stanley J. and Persily, Nancy A. ed. Hospitals and the Aged. Maryland: Aspen Systems Corporation, 1984; pg. 51-52.*
3. *Ibid: No. 2; p. 62.*
4. *Ibid: No. 2; pg. 43-44.*
5. *Ibid: No. 2; p. 106.*
6. *Ibid: No. 2; p. 106.*
7. *Ibid: No. 2; pg. 39-42.*
8. *Palm Beach Regional Visiting Nurse Associaition, Inc.: February 1984 Data Report.*
9. *Ibid: No. 2; pg. 39-42.*
10. *District IX Long Term Care Ombudsman Committee. A Directory and Guide to Long Term Care Facilities: District IX.*
11. *Ibid: No. 10.*
12. *Florida Department of Health and Rehabilitative Services. 1981 Florida State Health Plan Volume II p. 93.*
13. *Ibid: No. 12; p. 93.*
14. *Ibid: No. 2; pg. 36-37.*
15. *Ibid: No. 2; pg. 37-39.*
16. *Florida State Long Term Care Ombudsman Council. Annual Report of the Long Term Care Ombudsman Council 1983. p. 13.*
17. *Ibid: No. 16; p. 14.*
18. *Branch, Laurence G. and Jette, Alan M.: A Prospective Study of Long Term Care Utilization Among the Aged. American Journal of Public Health, December, 1982; 72: 1376.*
19. *Florida Nursing Home Bed Need Methodology Workgroup. Summary of Activities (Unpublished Paper), May 1982.*
20. *Ibid: No. 16; p. 33.*

STATE OF FLORIDA
DEPARTMENT OF HEALTH AND REHABILITATIVE SERVICES

CHAPTER 10-5, FLORIDA ADMINISTRATIVE CODE
PROCEDURES FOR THE ADMINISTRATION OF SECTIONS 381.493 - 381.499, FLORIDA STATUTES, HEALTH FACILITIES AND HEALTH SERVICES PLANNING ACT

"NURSING HOME BED ALLOCATION METHODOLOGY"

10-5.11(21) Community Nursing Home Beds. A community nursing home bed is a nursing home bed not located within a life care facility certified under Chapter 651, Florida Statutes.

(a) Departmental Goal. The Department will consider applications for community nursing home beds in context with applicable statutory and rule criteria. The Department will not normally approve applications for new or additional community nursing home beds in any departmental service district if approval of an application would cause the number of community nursing home beds in that departmental service district to exceed the number of community nursing home beds calculated by the methodology described in subsection (21) (b), (c), (d), (e), (f), (g), and (h) of this rule.

(b) Need Methodology. In addition to relevant statutory criteria and applicable rule criteria to be used in considering need for new or additional community nursing home beds, the Department will determine if there is a projected need for new or additional community nursing home beds three years into the future according to the following methodology:

$$N = \frac{De}{Se} \times R \times P - Eb$$

where:

N is area-apecific allocation of community nursing home beds for the calendar year for which a projection is being made,

De is the percentage of elderly living in poverty in the relevant departmental service district according to the latest available U.S. Census,

Se is the percentage of elderly living in poverty in the State according to the latest available U.S. Census,

R is the statewide bed need ratio (27 community nursing home beds per 1,000 population age 65 years and older),

P is the population age 65 and older projected three years into the future residing in the relevant departmental district based on latest mid-range projections published by the Bureau of Economics and Business Research at the University of Florida, and

Eb is the number of existing and approved community nursing home beds within the relevant departmental service district.

(c) Sub-district Need Determination. The Department shall use the sub-district designations shown in Attachment 12 in making certificate of need determinations. The need ratio for each sub-district shall be the same as that specified for the district of which it is a part. Attachment 12 may be amended, as appropriate, to reflect revised sub-district designations adopted by the local health councils.

(d) Current Utilization. Consideration of additional nursing home beds within a district will be based both upon need as determined in subsections (b) and (c) of this rule and the extent of current utilizaiton relevant to licensed community nursing home bed capacity, determined as follows:

$$Uc = \frac{PC}{Lb}$$

where:

Uc is current utilization of community nursing home beds.

PC is the average patient census during the most recent six month period for which the Department has data available.

Lb is the current number of licensed community nursing home beds.

(e) Need Relationships. Within a particular sub-district of a district, one of four bed need/availability relationships may be evident, as follows:

1. c1: Both sub-district and district indicate a need for additional bed capacity considering both licensed and approved beds.
2. c2: The sub-district indicates a need for additional bed capacity, but the district as a whole shows no additional need considering both licensed and approved beds.
3. c3: The sub-district shows no additional need, but the district as a whole does exhibit a need for additional bed capacity considering both licensed and approved beds.
4. c4: Neither the sub-district nor the district shows a need for additional bed capacity considering both licensed and approved beds.

(f) Current Utilization Thresholds. Consideration of applications for additional community nursing home beds will be premised on both the projected need for new bed capacity and current utilization (Uc). For each of the four need relationships defined in (e), a unique set of current utilization thresholds is hereby established as follows:

1. c1: Licensed beds in the sub-district must have an average current utilization rate of .85 or higher.
2. c2: Licensed beds in the sub-district must have an average current utilization rate of .90 or higher.
3. c3: Licensed beds in the sub-district must have an average current utilization rate of .95 or higher. Beds within the district, but outside the sub-district, must have an average current utilization rate below .85.

4. c4: Licensed beds in the sub-district must have an average current utilization rate of .95 or higher. Beds within the district, but outside the sub-district must have an average current utilization of .90 or higher.

(g) Prospective Utilization. When the appropriate current utilization threshold is satisfied, and assuming other relevant standards and criteria are met, additional beds may be added up to the point at which further bed additions would cause prospective utilization (Up) for the sub-district to drop below the prospective base rates specified in (h). Prospective utilization will be determined as follows:

$$Up = \frac{PC}{(Eb + Pb)}$$

where:

Up is prospective utilization of community nursing home beds.

PC is the average patient census within the area during the most recent six month period prior to the filing of the C.O.N. application(s) under consideration for which the Department has data available.

Eb is the current number of licensed and approved community nursing home beds within the area.

Pb is the number of additional beds being proposed.

(h) Prospective Base Rates of Utilization. The prospective base rate of utilization for each of the four need relationships is as follows:

1. c1: 80%
2. c2: 80%
3. c3: 85%
4. c4: 85%

10-5.11(22) Sheltered Nursing Home Beds.

(22) A sheltered nursing home bed is a nursing home bed within a life care facility certified under Chapter 651, Florida Statutes.

(a) Need Methodology. In addition to the relevant statutory criteria and other applicable rule criteria, the Department will not normally approve an application for new or additional sheltered nursing home beds if approval of the application would result in a number of sheltered nursing home beds that exceed one for every four residential units in the life care facility.

(b) Availability of Sheltered Nursing Home Beds to Non-residents. Applicants for Certificates of Need to construct new or additional sheltered nursing home beds may seek approval to allow use of sheltered nursing home beds by patients who are non-residents of the life care facility. Such applications may be approved if the Department determines that the proposal will have no significant adverse impact upon other community nursing homes in the district.

As a condition to seeking and retaining such approval, the applicant must agree to admit patients who are non-residents of the life care facility for a period not to exceed three years from the issuance date of the life care facility's initial State nursing home license.

Specific Authority: 381.494(5), (7), (8), 381.031 (1)(g)
11, F.S.

Implemented: 381.494(7), F.S.

History: New

Purchase Order No.: 009364

Effective Date: March 1, 1983

DISTRICT IX

Subdistrict	65+ Pop.	1986 Need	Licensed	T/P*	Beds Available-CON	Beds Approved for CON
Indian River	17,330	342	232	95/85	--	120
Martin	22,535	445	302	90/80	--	120
Okeechobee	3,710	73	0	95/85	--	90
Palm Beach	198,747	3,923	2,646	95/85	--	1,440
St. Lucie	22,004	434	537	95/85	69	0
		5,217	3,717		69	1,770

POVERTY RATIO 9.28/12.70 = .73

BED NEED RATIO 19.7

*T/P indicates the appropriate utilization Threshold and Prospective rate to be applied to each subdistrict as prescribed in HRS, Chapter 10-5.11(21).

Produced by PDCHP
2/29/84

The following two data forms were submitted to this Council after the deadline and are included here as Appendix B so that the reader can utilize them. With the submittal of these data forms, 100% participation in the annual survey has been achieved.

* * * * *

Please Note: *The licensed bed occupancy rate for this nursing home rose from 94.4% in 1982 to 97.5% in 1983 and the impact on the entire District is minimal.*

DISTRICT IX HEALTH COUNCIL, INC.

ANNUAL REPORT - 1983
NURSING HOME UTILIZATION

Nursing Home THE KING DAVID CENTER AT PALM BEACH

Person Completing Form AMELIA V. KLEIN

Telephone Number (305) 844-4343 **Date** April 18, 1984

I	Average Number of Licensed Beds During 1983 (Total Beds)		191
	A.	Licensed Skilled Beds	178
	B.	Licensed Intermediate Care Beds	13
	C.	Other: Please Specify	
II	Average Number of Available Beds During 1983 (Total Beds)		191
	A.	Available Skilled Beds	178
	B.	Available Intermediate Care Beds	13
	C.	Other: Please Specify	
III	Total Patient Days During 1983		67,992
	A.	Medicaid Patient Days	52,517
	B.	Medicare Patient Days	5,716
	C.	Private Pay Patient Days	9,759
	D.	Paid Reservation Days	
	E.	Other Patient Days: SPECIFY OTHER INTO SUBCATEGORIES:	

COMMENTS:

Please complete this form and return to:
District IX Health Council, Inc.
4455 Westroads Drive
West Palm Beach, Florida 33407

Please Note: *The licensed bed occupancy rate for this nursing home remains at 99.2% for both 1982 and 1983.*

DISTRICT IX HEALTH COUNCIL, INC.

ANNUAL REPORT - 1983
NURSING HOME UTILIZATION

Nursing Home LAKE WORTH HEALTH CARE CENTER

Person Completing Form ____________________

Telephone Number ____________________ **Date** May 1, 1984

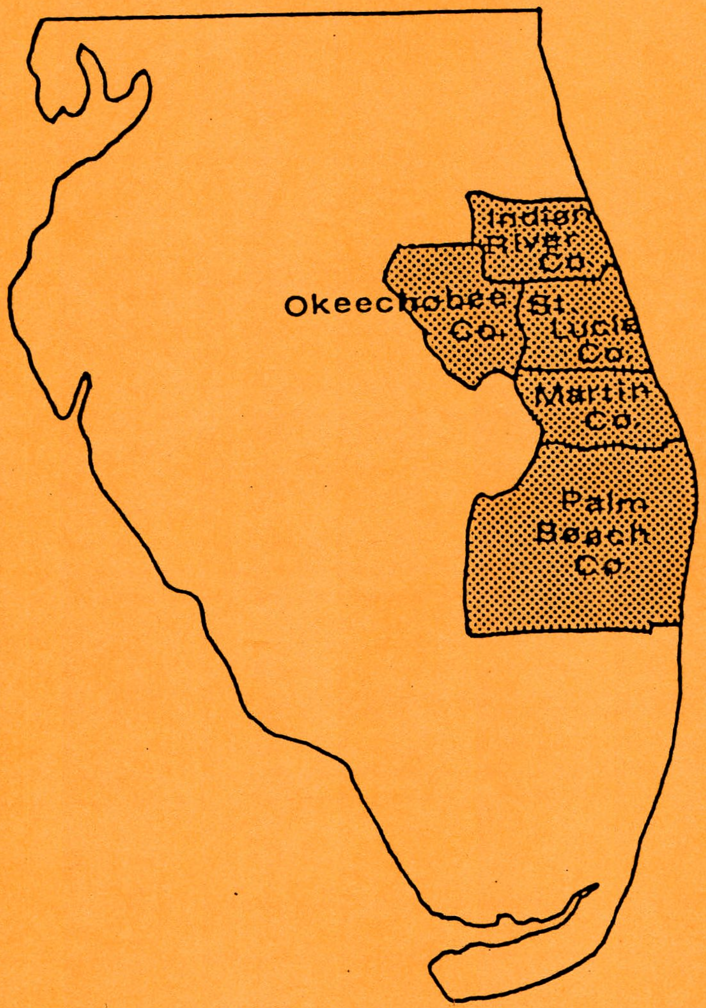
I	Average Number of Licensed Beds During 1983 (Total Beds)		162
	A.	Licensed Skilled Beds	
	B.	Licensed Intermediate Care Beds	
	C.	Other: Please Specify	
II	Average Number of Available Beds During 1983 (Total Beds)		162
	A.	Available Skilled Beds	
	B.	Available Intermediate Care Beds	
	C.	Other: Please Specify	
III	Total Patient Days During 1983		58,628
	A.	Medicaid Patient Days	48,633
	B.	Medicare Patient Days	1,641
	C.	Private Pay Patient Days	8,354
	D.	Paid Reservation Days	None
	E.	Other Patient Days: SPECIFY OTHER INTO SUBCATEGORIES:	None

COMMENTS: ____________________

Please complete this form and return to:
District IX Health Council, Inc.
4455 Westroads Drive
West Palm Beach, Florida 33407

DISTRICT IX HEALTH PLAN

1984



ACUTE CARE

ACUTE CARE

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ACUTE CARE

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ACUTE CARE

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INTRODUCTION

Hospitals form the cornerstone for the delivery of health care services within the community. Community hospitals in this section are defined as non-Federal short term general hospitals whose facilities and services are available to the public. In Florida, there are 253 hospitals, of which 216 are community hospitals. The Florida Hospital Cost Containment Board reported in its 1983 Hospital Budget Data that:

> *"Hospitals will charge about 1.8 million patients roughly $7.6 billion in Florida in 1983. They will collect about 75% of those charges ($5.7 billion) to cover expenses of about $5.4 billion.*
>
> *"The average patient admitted to a hospital in Florida in 1983 will be charged $3,811 and will stay in the hospital slightly more than one week. Over 52% of those patients will be Medicare recipients. Of the $3,811 charge for an average admission, the hospital will collect $2,880 to cover hospital costs of $2,720. Slightly more than 46% of those costs will be due to salary expense associated with the admission. Statewide, hospitals will employ just under one full time employee for each eight hour shift for every patient in a hospital. That average employee will be paid slightly over $17,165 per year in salary or wages."*

In 1981, national health care expenditures equalled $287 billion, of which 41% ($118 billion) was for hospital care. Health Care Financing Administration figures presently show that hospitals represent 42% of total spending for health care and health care is now 10.5% of the Gross National Product.

The hospital industry is in a state of flux. With the advent of the new Medicare Diagnostic Related Groups prospective reimbursement, some hospitals will lose money on some patients but this loss should be offset by a gain through other patients.As Health Maintenance Organizations and Preferred Provider Organizations grow, there will be less incentive to hospitalize and shorter lengths of stay. Competition among health care providers has also increased during 1983 as hospitals compete with alternative delivery systems. A nationwide survey conducted by the National Research Corporation indicates that 75% of all hospitals surveyed now offer alternative care and 15% more plan to offer such services soon. Alternative services identified in the survey include birthing centers, home health care, alcohol treatment, rehabilitation centers, primary care centers, occupational health, wellness centers, nursing homes, ambulatory care and urgent care centers.

A hospital bed, with all the associated costs, has become our most costly health care resource. Because of the economics of our present health care system, unused hospital beds drain limited health care resources and divert funds from other needed services. Unused hospital beds tend to increase hospital admissions and length of hospital stay. The cost of an unused, fully staffed hospital bed is estimated to be between $25,000 and $30,000 annually. Unused, excess hospital beds add to the cost of hospitalization.

The District IX Health Council, Inc. has a responsibility to plan for the appropriate use and development of hospital resources within District IX. Planning is accomplished with respect to hospital services, through the State of Florida Certificate of Need Law and by individual hospitals within the five county health service area.

The purpose of the Certificate of Need program is the effective and efficient development of health care facilities that will meet community needs within the limits of available resources. Every consideration is given to the elimination of unnecessary *duplication of health facilities while strengthening the competitive forces in the health care industry.*

Current Capacity

As of June 1, 1984, District IX had 4545 licensed and/or approved acute care general hospital beds. Of this, 632 beds, or almost 14% of the total, were in some phase of construction. The 150 bed Port St. Lucie Medical Center (St. Lucie County) opened its doors on September 21, 1983. The 185 bed West Boca Raton Medical Center held its ground breaking ceremony in early 1984 (Palm Beach County). Two other hospitals have been approved, one in the North Palm Beach Subdistrict and one in the South Palm Beach Subdistrict. The Palms West Community Hospital will be 117 beds and will be built by Hospital Corporation of America in Loxahatchee. The Wellington Hospital Medical Center will be built in Wellington and will consist of 120 osteopathic beds owned by Osteopathic Medical Hospitals, Inc. and Universal Health Systems, Inc. Table I points to the breakdown of licensed beds, by hospital and subdistrict and indicates the construction status of new beds.

TABLE I

TOTAL HOSPITAL BEDS
MAY, 1984
LICENSED AND/OR APPROVED

Area	**Existing Licensed Beds**	**BedsUnder Construction**	**Beds Approved But Not Under Construction**	**Total**
Indian River Memorial Hosital	*240*	*53*		*293*
Humana Hospital Sebastian	*117*			*117*
Indian River County Subdistrict	**357**	**53**		**410**
Martin Memorial Hospital	*310*		*26*	*336*
Lawnwood Medical Center	*225*		*50*	*275*
Port St. Lucie Medical Center	*150*			*150*
Martin/St. Lucie Subdistrict	**685**		*76*	**761**
H.H. Raulerson, Jr. Memorial Hosp.	*101*			*101*
Okeechobee Subdistrict	**101**			**101**
Bethesda Memorial Hospital	*350*			*350*
Boca Raton Community Hospital	*394*			*394*
Delray Community Hospital	*160*		*51*	*211*
Doctors Hospital	*200*			*200*
J.F. Kennedy Memorial Hospital	*333*			*333*
Wellington Medical Center			*120*	*120*
West Boca Raton Medical Center		*185*		*185*
South Palm Beach Subdistrict	**1,437**	**185**	**171**	**1,793**
Humana Hospital Palm Beaches	*162*			*162*
Everglades Memorial Hospital	*54*		*9*	*63*
Glades General Hospital	*73*			*73*
Good Samaritan Hospital	*326*			*326*
Palm Beach Gardens Medical Ctr.	*204*			*204*
Palm Beach/Martin Co. Med. Ctr.	*156*			*156*
Palm Coast Community Hospital			*117*	*117*
St. Mary's Hospital	*358*		*21*	*379*
North Palm Beach Subdistrict	**1,333**		**147**	**1,480**
DISTRICT IX	**3,913**	**238**	**394**	**4,545**

Table II breaks down the 4545 licensed and approved beds in District IX by major service category for each hospital, as well as each subdistrict.

TABLE II

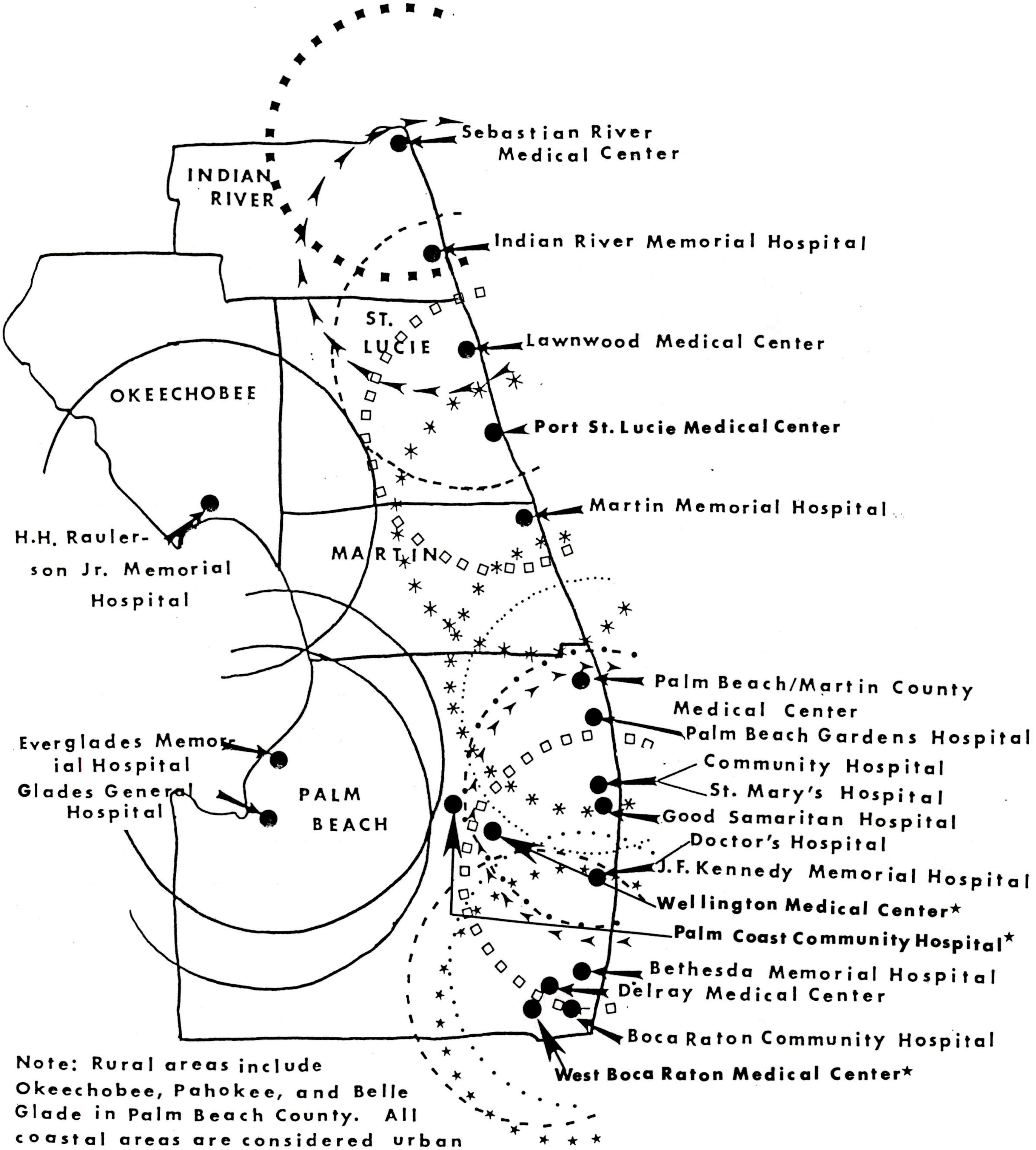
HOSPITAL BEDS BY MAJOR SERVICE CATEGORY
DISTRICT IX
MAY, 1984

Area	Licensed or Approved Beds	Medical/ Surgical	OB	ICU/CCU & Other*	Pediatrics
Indian River Memorial Hospital	293	230	21	18	24
Humana Hospital Sebastian	117	103	6	8	--
Indian River County Subdistrict	**410**	**333**	**27**	**26**	**24**
Martin Memorial Hospital	336	280	20	23	13
Lawnwood Medical Center	275	226	16	18	15
Port St. Lucie Medical Center	150	138	--	12	--
Martin/St. Lucie Subdistrict	**761**	**644**	**36**	**53**	**28**
H.H. Raulerson, Jr. Mem. Hosp.	101	84	8	7	2
Okeechobee Subdistrict	**101**	**84**	**8**	**7**	**2**
Bethesda Memorial Hospital	350	281	18	36	15
Boca Raton Community Hospital	394	348	--	35	11
Delray Community Hospital	211	171	--	40	--
Doctors Hospital	200	188	--	12	--
J. F. Kennedy Memorial Hospital	333	295	--	22	16
Wellington Medical Center	120	100	--	8	12
West Boca Raton Medical Center	185	154	15	16	--
South Palm Beach Subdistrict	**1,793**	**1,537**	**33**	**169**	**54**
Humana Hospital Palm Beaches	162	152	--	10	--
Everglades Memorial Hospital	63	45	9	--	9
Glades General Hospital	73	39	6	6	22
Good Samaritan Hospital	326	233	26	22	45
Palm Beach Gardens Medical Center	204	153	22	11	18
Palm Beach/Martin Co. Med. Ctr.	156	141	--	15	--
Palm Coast Community Hospital	117	109	--	8	--
St. Mary's Hospital	358	260	24	44	30
North Palm Beach Subdistrict	**1,459**	**1,132**	**87**	**116**	**124**
DISTRICT IX TOTAL	**4,545**	**3,730**	**191**	**371**	**232**

*"Other" includes ICU/CCU step-down units.

The map in Figure 1 shows the location of all 21 acute care hospitals in District IX. The service area of each existing facility is also indicated on the map. It is easily noted that almost all of the hospitals are situated along the coast where the majority of the population lies.

Figure I: ACUTE CARE HOSPITALS IN DISTRICT IX LOCATION AND MAJOR SERVICE AREAS JUNE, 1984


INDIAN RIVER
ST. LUCIE
OKEECHOBEE
MARTIN
PALM BEACH
Sebastian River Medical Center
Indian River Memorial Hospital
Lawnwood Medical Center
Port St. Lucie Medical Center
Martin Memorial Hospital
H.H. Raulerson Jr. Memorial Hospital
Everglades Memorial Hospital
Glades General Hospital
Palm Beach/Martin County Medical Center
Palm Beach Gardens Hospital
Community Hospital
St. Mary's Hospital
Good Samaritan Hospital
Doctor's Hospital
J.F. Kennedy Memorial Hospital
Wellington Medical Center*
Palm Coast Community Hospital*
Bethesda Memorial Hospital
Delray Medical Center
Boca Raton Community Hospital
West Boca Raton Medical Center*

Note: Rural areas include Okeechobee, Pahokee, and Belle Glade in Palm Beach County. All coastal areas are considered urban for this map.

*Not open, therefore, no service area indicated.

UTILIZATION

Historical

The District IX Health Council has continued the 14-year tradition of maintaining hospital utilization data as established by the predecessor organization of the health systems agency. At the present time, monthly utilization reports are submitted by each hospital and appropriate calculations are made.

Table III indicates the growth pattern of licensed beds in the area. From 1970 to 1983, the number of acute care beds increased 114% and in the past three years, District IX has seen the approval of over 1200 beds.

TABLE III

HOSPITAL BEDS
1970--1983

Year	**Licensed ***	**Available****
1970	1,816	1,794
1971	1,864	1,832
1972	2,078	2,018
1973	2,335	2,124
1974	2,422	2,329
1975	2,625	2,519
1976	2,712	2,663
1977	2,771	2,711
1978	2,979	2,833
1979	3,245	2,991
1980	3,309	3,202
1981	3,339	3,254
1982	3,619	3,479
1983	3,881	3,771

**Licensed: Number of beds licensed by the State.*
***Available: Number of beds opened, staffed and available for occupancy.*

Figures 2 and 3 depict the District trend over the past twelve years. Although the number of patient days has shown a steady increase, the licensed bed occupancy rate for the area has been variable.

Figure 4 shows occupancy rates by major service category from 1980 through 1983. From 1982 to 1983, the overall occupancy rate dropped slightly. Obstetrics, ICU/CCU and Pediatric beds saw increased utilization in 1983.

FIGURE 2

DISTRICT IX

LICENSED BEDS
ANNUAL OCCUPANCY RATES
1970 - 1982

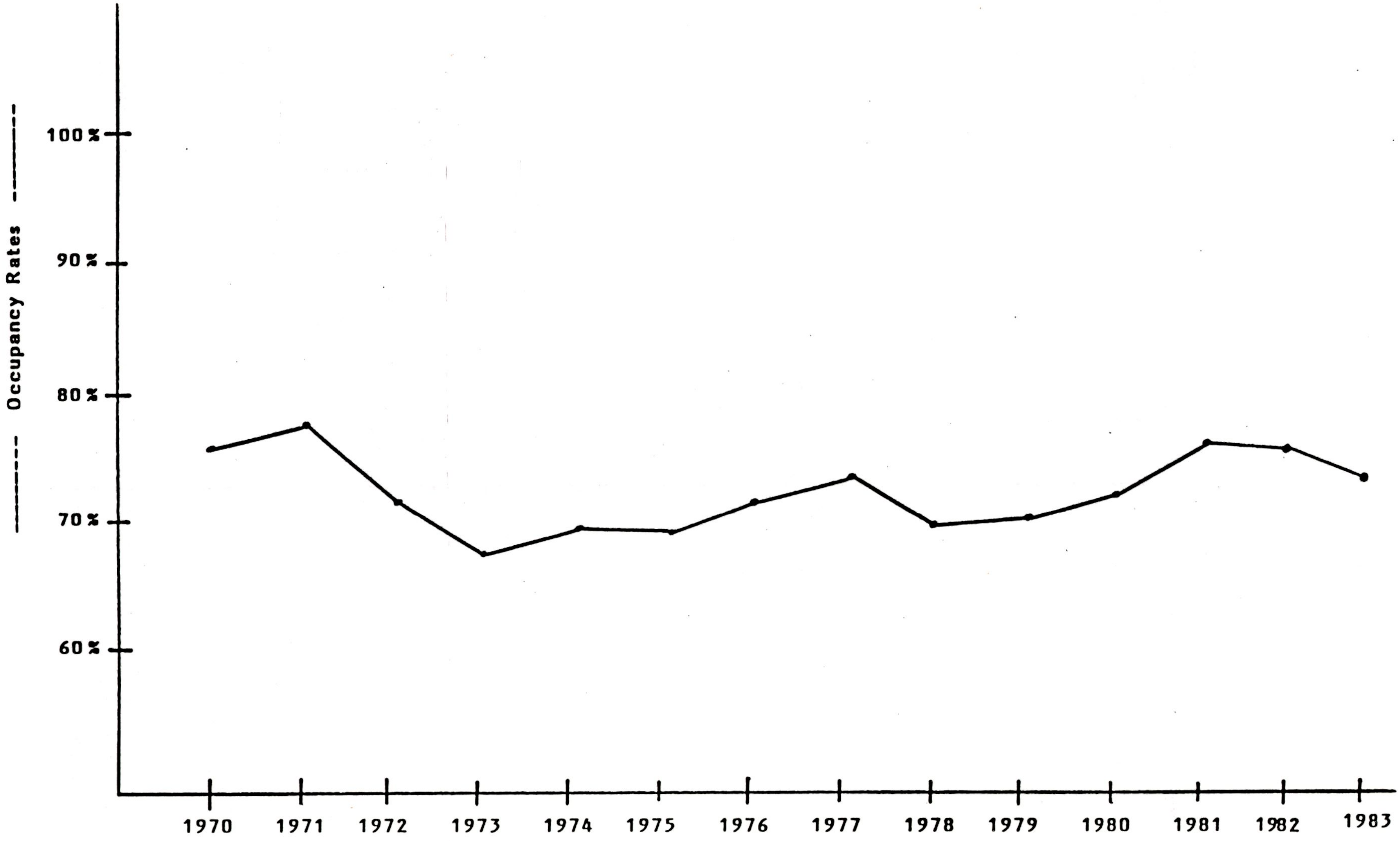


FIGURE 3
PATIENT DAYS
DISTRICT IX
1970 -- 1982

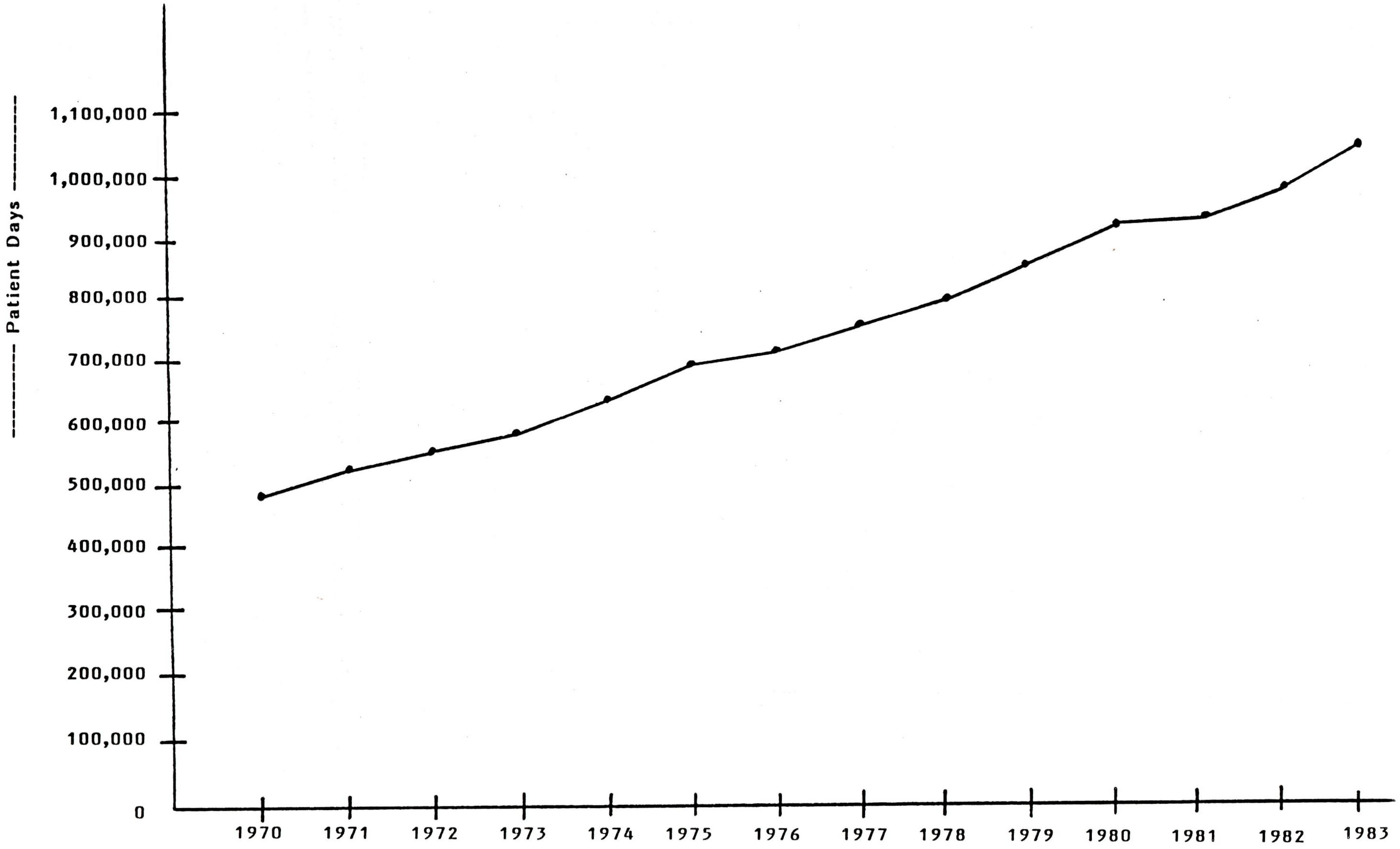
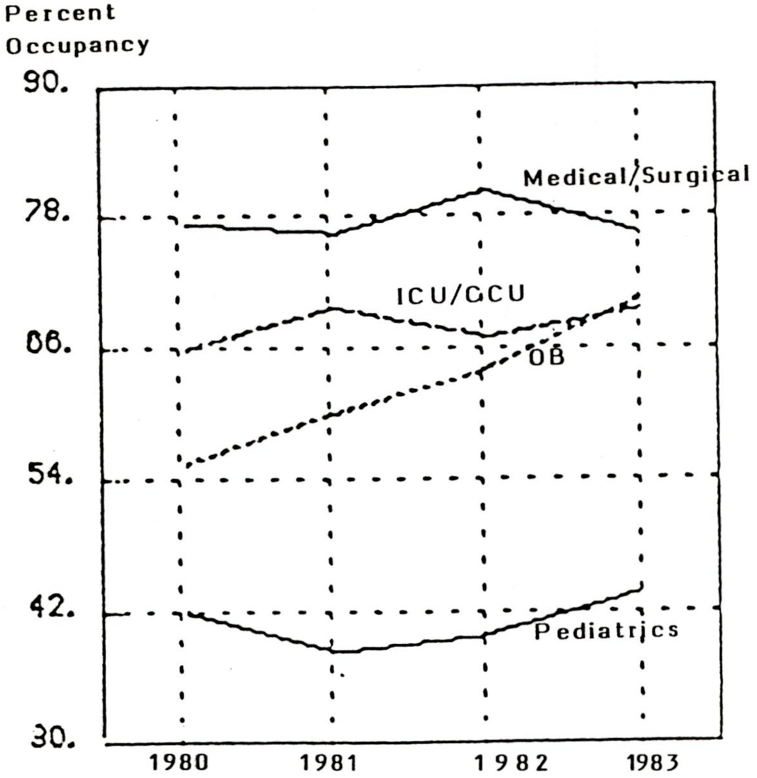


Figure 4

DISTRICT IX UTILIZATION BY

BY SERVICE CATEGORY 1980-1983



1983 Utilization

Summary

In 1983, the five county service area experienced an approximate 7.2% increase in general acute care hospital beds (262 beds from 1982). This growth was primarily in medical/surgical beds. The Port St. Lucie Medical Center is the only new facility and its doors opened on September 21, 1983. This new hospital accounts for much of the increase in area bed capacity. Located in St. Lucie County, this 150-bed facility is owned by Hospital Corporation of America, Inc.

The eighteen acute care hospitals averaged a licensed bed occupancy rate of 73.7% and provided 1,004,684 patient days of care in 1983. As illustrated in Figure 5, the Indian River County Subdistrict had the highest occupancy rate (81.3%) and the North Palm Beach Subdistrict had the lowest (66.9%).

The Average Length of Stay (ALOS) within the District remained at 6.9 days, the same as in 1982. The South Palm Beach Subdistrict continues to have the longest ALOS in 1983 (7.7 days) and the North Palm Beach Subdistrict continues to have the shortest (6.0 days). Declining lengths of stay were noted beginning in October, 1983 for most hospitals and continues to be noted in the first few months of 1984.

Figure 5
1983 OVERALL LICENSED BED OCCUPANCY RATE
BY SUBDISTRICT

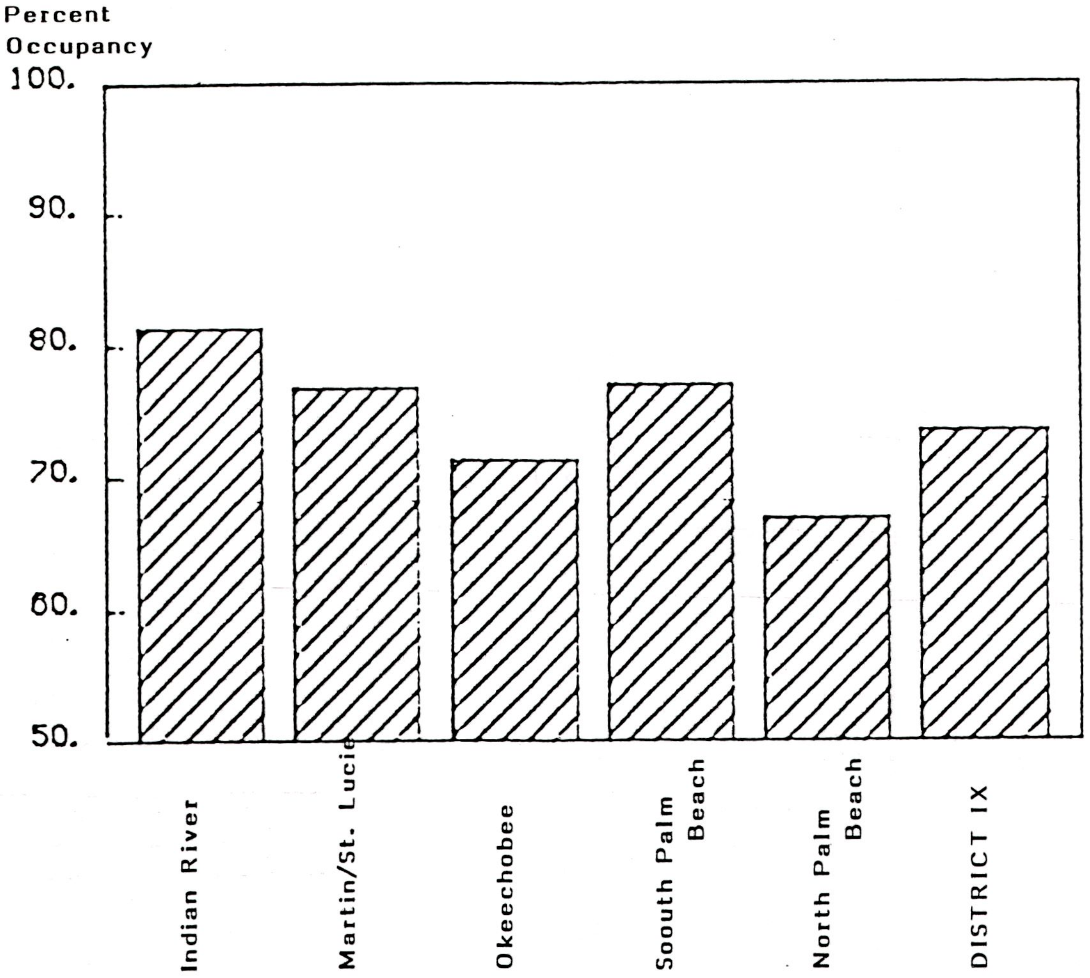


TABLE IV

HOSPITAL UTILIZATION IN DISTRICT IX - 1983

SUMMARY DATA**

Area	Beds		Patient Days	Lic. Bed Occupancy Rate	Number of Admissions	Average Length of Stay	E.R. Visits	Number of Births
	Lic.	Avail.						
Indian River Memorial Hospital	240	240	77,027	87.9	11,756	6.6	25,037	918
Humana Hospital Sebastian	103	103	24,776	65.9	3,005	8.2	5,482	0
Indian River County Subdistrict	**343**	**343**	**101,803**	**81.3**	**14,761**	**6.9**	**30,519**	**918**
Martin Memorial Hospital	310	298	83,896	74.1	13,098	6.4	31,819	1,100
Lawnwood Medical Center	225	225	71,538	87.1	9,664	7.4	26,878	1,239
Port St. Lucie Medical Center [1]	150	150	5,374	38.9	753	7.1	1,985	0
Martin/St. Lucie Subdistrict	**685**	**673**	**160,808**	**76.9**	**23,515**	**6.8**	**60,682**	**2,339**
H.H. Raulerson, Jr. Memorial Hospital	101	101	26,330	71.4	3,722	7.1	10,980	217
Okeechobee Subdistrict	**101**	**101**	**26,330**	**71.4**	**3,722**	**7.1**	**10,980**	**217**
Bethesda Memorial Hospital	350	350	86,402	67.6	12,707	6.8	23,292	2,288
Boca Raton Community Hospital	394	390	123,117	85.6	14,408	8.5	28,795	0
Delray Community Hospital	160	152*	37,723	64.6	5,351	7.0	11,115	0
Doctors Hospital	200	200	56,379	77.2	7,109	7.9	19,142	0
J. F. Kennedy Memorial Hospital [2]	333	297*	91,095	84.0	11,619	7.8	29,115	0
West Boca Raton Medical Center	---------	---------	---------	---UNOPENED---	---------	---------	---------	---------
South Palm Beach Subdistrict	**1,437**	**1,389**	**394,716**	**77.2**	**51,194**	**7.7**	**111,495**	**2,288**
Humana Hospital - Palm Beaches	162	162	49,007	82.9	5,563	8.8	6,632	0
Everglades Memorial Hospital	54	54	16,043	81.4	3,478	4.6	5,794	1,074
Glades General Hospital	73	65*	15,790	59.3	3,042	5.2	13,246	273
Good Samaritan Hospital	326	284*	62,222	52.3	14,215	4.4	26,380	2,132
Palm Beach Gardens Medical Center	204	204	40,835	54.8	7,345	5.6	13,246	817
Palm Beach/Martin Co. Med. Ctr.	156	156	38,530	67.7	5,387	7.2	10,426	0
St. Mary's Hospital	340	340	98,600	79.5	14,425	6.8	18,303	2,188
North Palm Beach Subdistrict	**1,315**	**1,265**	**321,027**	**66.9**	**53,455**	**6.0**	**94,027**	**6,484**
DISTRICT IX TOTAL	**3,881**	**3,771**	**1,004,684**	**73.7**	**146,647**	**6.9**	**307,667**	**12,246**

Please Note: Due to a varying definition and accounting of transfer admissions by each hospital, the Average Length of Stay (ALOS) may not be comparable in all cases.

Rounding Error: Numbers have been rounded upwards to the nearest tenth when appropriate (.05 or above).

[1] Opened September 21, 1983. Data for October, November and December adjusted for an annualized rate in the totals.

[2] For the first nine months of 1983, JFK had 285 licensed beds.

*Average number of beds in 1983.

**The Wellington Hospital Medical Center and the Palms West Community Hospital are not under construction and are not included in this table.

Medical/Surgical Utilization

In 1983, approximately 85% of all acute care inpatient days provided to District IX consumers were in the medical/surgical category. In 1982, the medical/surgical licensed bed occupancy rate for 2,959 beds was 80.3%. In 1983, with 3,204 medical/surgical beds, the licensed bed occupancy rate was 76.3%. In 1983, the Indian River County Subdistrict had the highest occupancy rate (84.4%) and the Okeechobee Subdistrict had the lowest (70.8%). The North Palm Beach Subdistrict had the shortest length of stay (6.5 days) and the Indian River Subdistrict had the longest length of stay (8.1 days).

Figure 6
1983 MEDICAL/SURGICAL OCCUPANCY RATES BY SUBDISTRICT

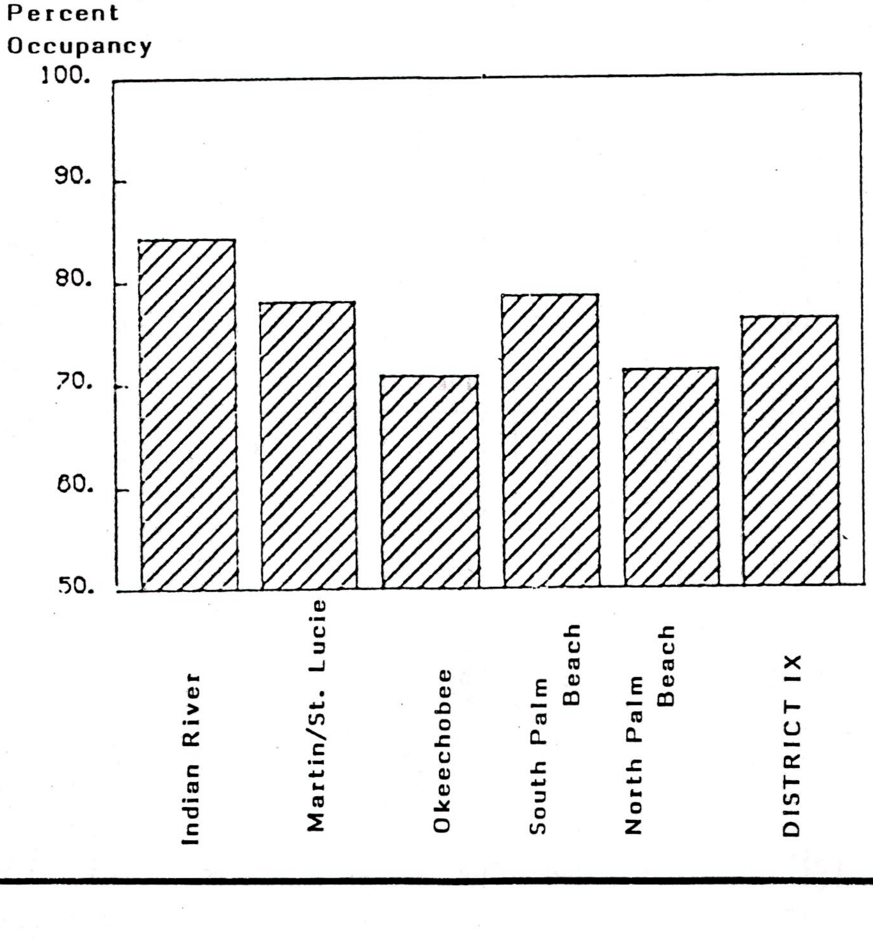


TABLE V
1983 - ANNUAL
MEDICAL/SURGICAL UTILIZATION **

Area	Beds		Patient Days	Lic. Bed Occupancy Rate	Number of Admissions	Average Length of Stay
	Licensed	Available				
Indian River Memorial Hospital[A]	177	177	61,265	94.8	7,845	7.8
Humana Hospital Sebastian	91	91	21,269	64.0	2,306[3]	9.2
Indian River County Subdistrict	**268**	**268**	**82,534**	**84.4**	**10,151**	**8.1**
Martin Memorial Hospital[A]	262	250	71,544	74.8	11,069	6.5
Lawnwood Medical Center	172	172	56,991	90.8	7,729	7.4
Port St. Lucie Medical Center[1]	138	138	4,774	37.6	618	7.7
Martin/St. Lucie Subdistrict	**572**	**560**	**133,309**	**78.0**	**19,416**	**6.9**
H.H. Raulerson, Jr. Memorial Hosp.	84	84	21,701	70.8	3,116	7.0
Okeechobee Subdistrict	**84**	**84**	**21,701**	**70.8**	**3,116**	**7.0**
Bethesda Memorial Hospital	281	281	70,012	68.3	11,784	5.9
Boca Raton Community Hospital	348	351	112,105	88.3	16,127	7.0
Delray Community Hospital[A]	145	137*	34,085	64.4	4,626	7.4
Doctors Hospital	188	188	52,233	76.1	7,461	7.0
J. F. Kennedy Memorial Hospital[2]	295	258*	81,125	86.3	11,749	6.9
West Boca Raton Medical Center	---------	----------------	-----UNOPENE	D-----------	----------------	--------
South Palm Beach Subdistrict	**1,257**	**1,215**	**349,560**	**78.5**	**51,747**	**6.8**
Humana Hospital - Palm Beaches	152	152	45,857	82.7	5,980	7.7
Everglades Memorial Hospital	45	45	12,715	77.4	2,549	5.0
Glades General Hospital	39	39	10,004	70.3	1,342	7.5
Good Samaritan Hospital	233	191*	44,635	52.5	8,626	5.2
Palm Beach Gardens Medical Center[A]	153	153	34,714	62.2	6,695	5.2
Palm Beach/Martin Co. Med. Ctr.	141	141	36,740	71.4	5,702	6.4
St. Mary's Hospital	260	260	81,682	86.1	9,794	8.3
North Palm Beach Subdistrict	**1,023**	**981**	**266,347**	**71.3**	**40,688**	**6.5**
DISTRICT IX TOTAL	**3,204**	**3,108**	**853,451**	**76.3**	**125,118**	**6.8**

[A] These hospitals report "Other Monitored and Intermediate Care" beds (ICU Step-Down Unit). For our purposes, we have combined these figures with Medical/Surgical.

[1] Opened September 21, 1983. Data for October, November, and December adjusted for an annualized rate in the totals.

[2] For the first nine months of 1983, JFK had 245 licensed beds.

[3] Estimate

*Average number of beds in 1983.

**The Wellington Hospital Medical Center and the Palms West Community Hospital are not under construction and are not included in this table.

Obstetrical Utilization

Overall, District IX had nine fewer OB beds in 1983. Glades General Hospital converted nine of their OB beds to Medical/Surgical and Pediatric beds. The Obstetrical occupancy rate for District IX went from 64.2% in 1982 to 70.6% in 1983. The number of births from 1982-1983 increased less than 2% and the District-wide length of stay remained at 2.8 days.

Bethesda Memorial Hospital is the only existing hospital in the South Palm Beach Subdistrict that provides Obstetrical care (18 beds). In 1983, their licensed bed occupancy rate was 114.1%. Fifteen Obstetrical beds have been approved for the West Boca Raton Medical Center and these beds will eventually alleviate this shortage in the South Palm Beach Subdistrict.

It can be noted that Good Samaritan and St. Mary's Hospitals provided the only Obstetrical tertiary care in District IX through their Level III Neonatal Care Units.

Figure 7
1983 OBSTETRICAL OCCUPANCY RATES
BY SUBDISTRICT

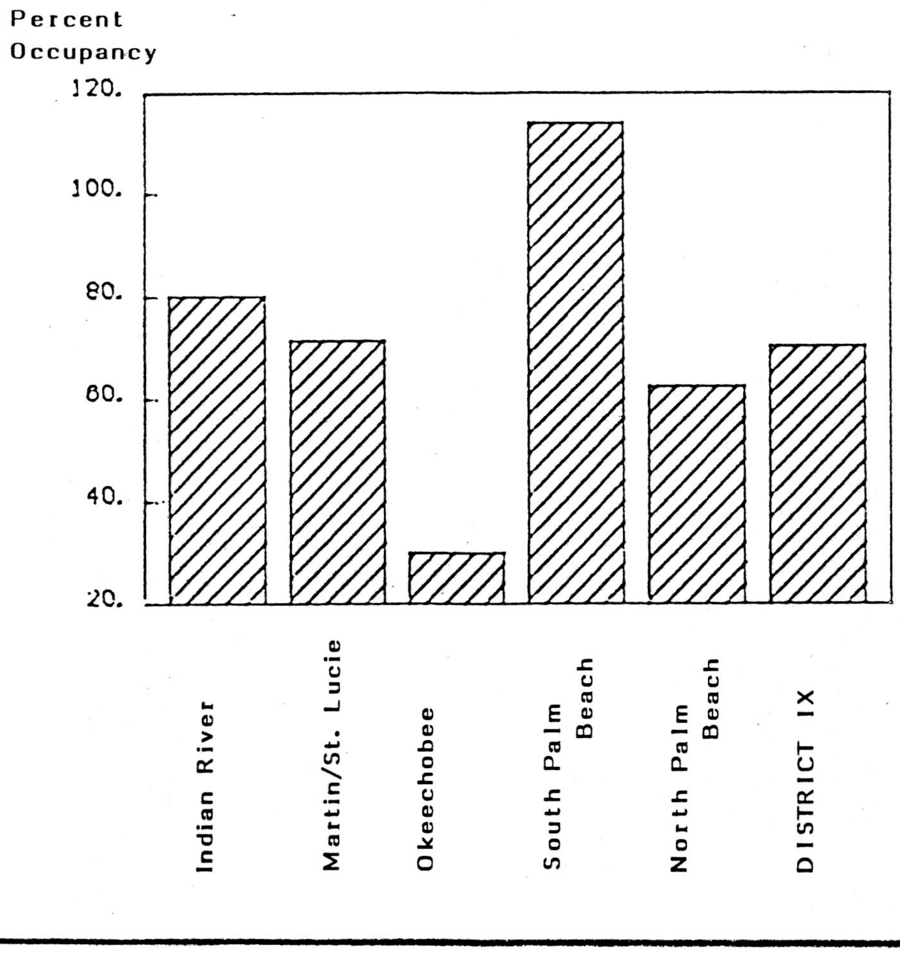


TABLE VI
1983 - ANNUAL
OBSTETRICAL UTILIZATION**

Area	Beds		Patient Days	Lic. Bed Occupancy Rate	Number of Admissions	Average Length of Stay
	Licensed	Available				
Indian River Memorial Hospital	21	21	6,129	80.0	1,625	3.8
Humana Hospital Sebastian	0	0	--	--	--	--
Indian River County Subdistrict	**21**	**21**	**6,129**	**80.0**	**1,625**	**3.8**
Martin Memorial Hospital	12	12	3,451	78.8	1,340	2.6
Lawnwood Medical Center	20	20	4,911	67.3	1,884	2.6
Port St. Lucie Medical Center	0	0	--	--	--	--
Martin/St. Lucie Subdistrict	**32**	**32**	**8,362**	**71.6**	**3,224**	**2.6**
H.H. Raulerson, Jr. Memorial Hosp.	8	8	885	30.3	284	3.1
Okeechobee Subdistrict	**8**	**8**	**885**	**30.3**	**284**	**3.1**
Bethesda Memorial Hospital	18	18	9,495	114.1	2,849	2.6
Boca Raton Community Hospital	0	0	--	--	--	--
Delray Community Hospital	0	0	--	--	--	--
Doctors Hospital	0	0	--	--	--	--
J. F. Kennedy Memorial Hospital	0	0	--	--	--	--
West Boca Raton Medical Center	---------	--------------	--UNOPENED-	-------------	----------------	---------
South Palm Beach Subdistrict	**18**	**18**	**7,495**	**114.1**	**2,849**	**2.6**
Humana Hospital - Palm Beaches	0	0	--	--	--	--
Everglades Memorial Hospital	9	9	3,328	101.3	1,365	2.4
Glades General Hospital	6	6	1,187	54.2	358	3.3
Good Samaritan Hospital	26	26	6,860	72.3	2,562	2.7
Palm Beach Gardens Medical Center	22	22	2,866	35.7	846	3.4
Palm Beach/Martin Co. Med. Ctr.	0	0	--	--	--	--
St. Mary's Hospital	24	24	5,648	64.5	2,187	2.6
North Palm Beach Subdistrict	**87**	**87**	**19,889**	**62.6**	**7,318**	**2.7**
DISTRICT IX TOTAL	**166**	**166**	**42,760**	**70.6**	**15,300**	**2.8**

**The Wellington Hospital Medical Center and the Palms West Community Hospital are not under construction and are not included in this table.

Pediatrics Utilization

District IX had eight additional pediatric beds in 1983. J. F. Kennedy Memorial Hospital converted two pediatric beds to another service while Glades General Hospital added ten Pediatric beds through conversion. The Pediatric licensed bed occupancy rate in District IX rose from 40.2% in 1982 to 43.9% in 1983. The average length of stay went up from 3.5 days to 3.8 days.

It should be noted that H. H. Raulerson, Jr. Memorial Hospital in Okeechobee County had only two pediatric beds with an annual licensed occupancy rate of 221% in 1983.

Figure 8
1983 PEDIATRIC OCCUPANCY RATES
BY SUBDISTRICT

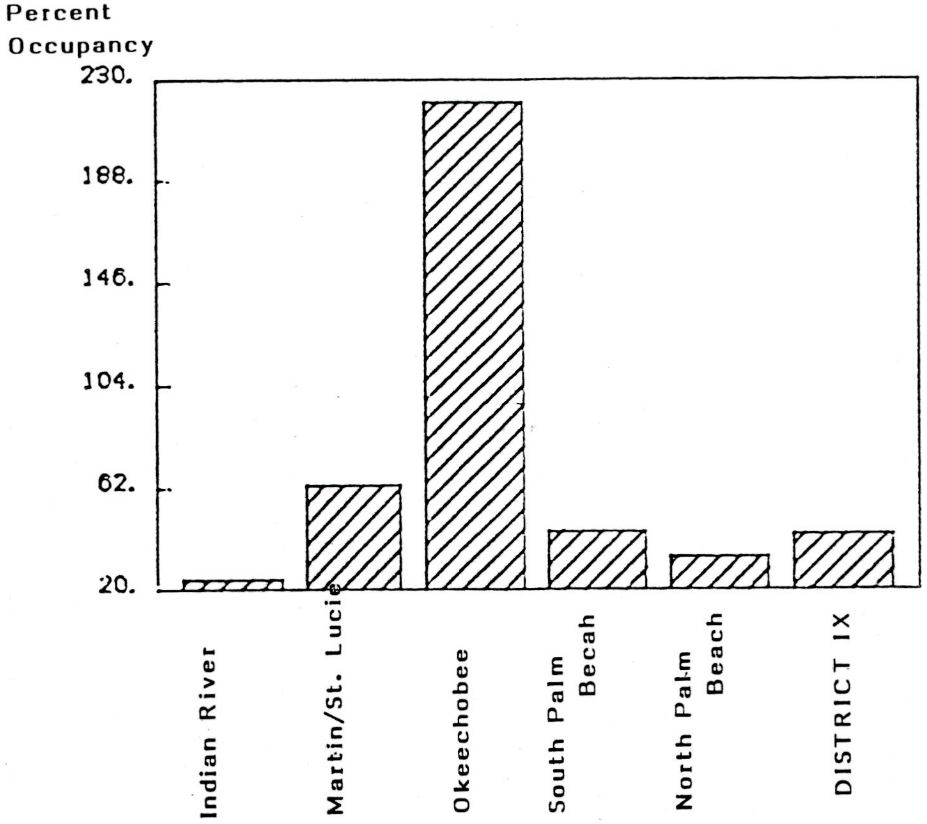


TABLE VII
1983 - ANNUAL
PEDIATRICS UTILIZATION **

Area	Beds		Patient Days	Lic. Bed Occupancy Rate	Number of Admissions	Average Length of Stay
	Licensed	Available				
Indian River Memorial Hospital	24	24	2,151	24.6	435	4.9
Humana Hospital Sebastian	0	0	--	--	--	--
Indian River County Subdistrict	**24**	**24**	**2,151**	**24.6**	**435**	**4.9**
Martin Memorial Hospital	13	13	2,527	53.3	689	3.7
Lawnwood Medical Center	15	15	4,011	73.3	1,107	3.6
Port St. Lucie Medical Center	0	0	--	--	--	--
Martin/St. Lucie Subdistrict	**28**	**28**	**6,538**	**64.0**	**1,796**	**3.6**
H.H. Raulerson, Jr. Memorial Hosp.	2	2	1,613	221.0	342	4.7
Okeechobee Subdistrict	**2**	**2**	**1,613**	**221.0**	**342**	**4.7**
Bethesda Memorial Hospital	15	15	2,398	43.8	652	3.7
Boca Raton Community Hospital	11	11	1,615	40.2	547	3.0
Delray Community Hospital	0	0	--	--	--	--
Doctors Hospital	0	0	--	--	--	--
J. F. Kennedy Memorial Hospital[b]	16	18*	3,170	49.6	449	7.1
West Boca Raton Medical Center	--------	--------------	---UNOPENED	------------	----------------	-------
South Palm Beach Subdistrict	**42**	**44**	**7,183**	**45.2**	**1,648**	**4.4**
Humana Hospital - Palm Beaches	0	0	--	--	--	--
Everglades Memorial Hospital	0	0	--	--	--	--
Glades General Hospital	22	14	3,352	41.7	655	5.1
Good Samaritan Hospital	45	45	5,216	31.8	1,794	2.9
Palm Beach Gardens Medical Center	18	18	1,700	25.9	644	2.6
Palm Beach/Martin Co. Med. Ctr.	0	0	--	--	--	--
St. Mary's Hospital	30	30	4,215	38.5	1,162	3.6
North Palm Beach Subdistrict	**115**	**107**	**14,483**	**34.5**	**4,255**	**3.4**
DISTRICT IX TOTAL	**211**	**205**	**31,968**	**43.9**	**8,476**	**3.8**

[b] For the first nine months of 1983, JFK had 18 licensed beds.

*Average number of beds during 1983.

**The Wellington Hospital Medical Center and the Palms West Community Hospital are not under construction and are not included in this table.

ICU/CCU Utilization

In 1983, District IX had seven additional ICU/CCU beds. With the opening of the Port St. Lucie Medical Center, twelve newly licensed ICU/CCU beds became available to residents of the Martin/St. Lucie County Subdistrict. Sebastian River Medical Center converted six ICU/CCU beds to another service and Boca Raton Community Hospital utilized an additional bed for ICU/CCU patients. The ICU/CCU licensed bed occupancy rate rose from 67.0% in 1982 to 69.9% in 1983. The length of stay dropped from 4.0 days to 3.6 days.

The Okeechobee Subdistrict, with seven ICU/CCU beds, had the highest occupancy rate (83.4%) and the North Palm Beach Subdistrict had the lowest (63.5%).

Figure 9
1983 ICU/CCU AND OTHER OCCUPANCY RATES BY SUBDISTRICT

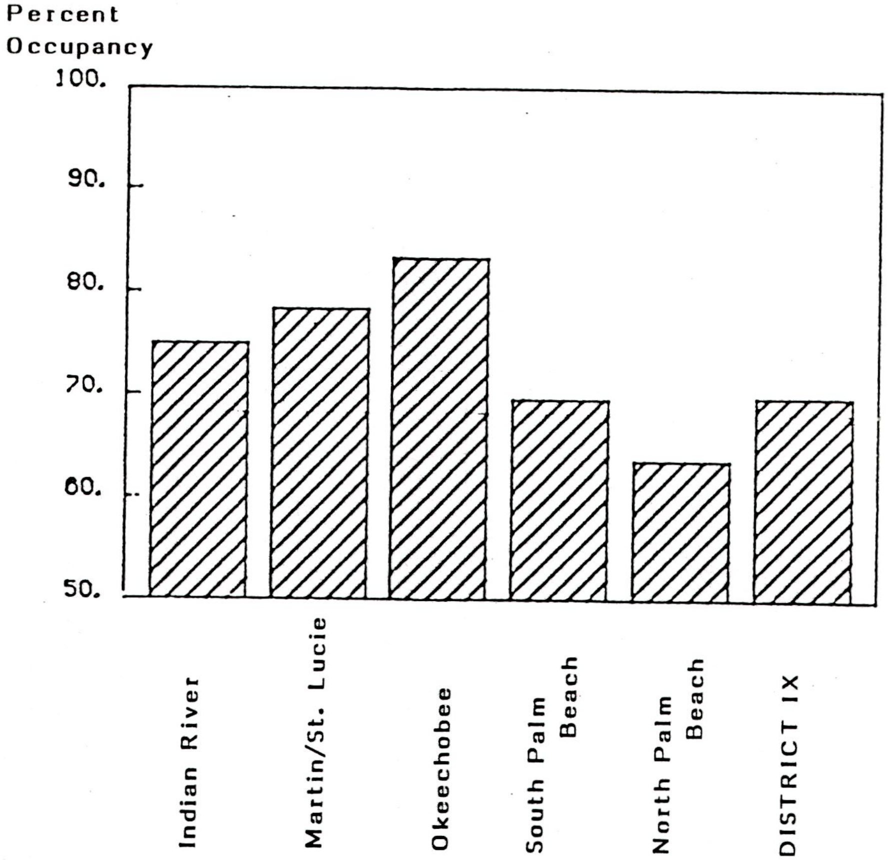


TABLE VIII
1983 - ANNUAL
ICU/CCU & OTHER UTILIZATION**

Area	Beds		Patient Days	Lic. Bed Occupancy Rate	Number of Admissions	Average Length of Stay
	Licensed	Available				
Indian River Memorial Hospital	18	18	4,730	72.0	926	5.1
Humana Hospital Sebastian	12	12	3,507	80.1	700[2]	5.0
Indian River County Subdistrict	**30**	**30**	**8,237**	**75.2**	**1,626**	**5.1**
Martin Memorial Hospital	23	23	6,374	75.9	*	*
Lawnwood Medical Center	18	18	5,625	85.6	1,676	3.4
Port St. Lucie Medical Center[1]	12	12	600	54.3	135	4.4
Martin/St. Lucie Subdistrict	**53**	**53**	**12,599**	**78.4**	**1,811**	**3.4**
H.H. Raulerson, Jr. Memorial Hosp.	7	7	2,131	83.4	595	3.6
Okeechobee Subdistrict	**7**	**7**	**2,131**	**83.4**	**595**	**3.6**
Bethesda Memorial Hospital	36	36	6,487	49.4	2,321	2.8
Boca Raton Community Hospital	35	25	9,397	73.6	2,063	4.6
Delray Community Hospital	15	15	3,638	66.4	725	5.0
Doctors Hospital	12	12	4,146	94.7	1,201	3.5
J. F. Kennedy Memorial Hospital	22	22	6,800	84.7	1,921	3.5
West Boca Raton Medical Center	--------	--------------	--UNOPENED-	------------	----------------	-------
South Palm Beach Subdistrict	**120**	**110**	**30,468**	**69.6**	**8,231**	**3.7**
Humana Hospital - Palm Beaches	10	10	3,150	86.3	991	3.2
Everglades Memorial Hospital	0	0	--	--	--	--
Glades General Hospital	6	6	1,247	56.9	521	2.4
Good Samaritan Hospital	22	22	5,511	67.6	1,416	3.9
Palm Beach Gardens Medical Center	11	11	2,098	52.3	763	2.7
Palm Beach/Martin Co. Med. Ctr.	15	15	1,790	32.7	722	2.5
St. Mary's Hospital	26	26	7,055	74.3	2,318	3.0
North Palm Beach Subdistrict	**90**	**90**	**20,851**	**63.5**	**6,731**	**3.1**
DISTRICT IX TOTAL	**300**	**290**	**74,286**	**69.9**	**18,994**	**3.6**

[1] Opened September 21, 1983. Data for October, November and December adjusted for an annualized rate in the totals.

[2] Estimate

**The Wellington Hospital Medical Center and the Palms West Community Hospital are not under construction and /are not included in this table

*Included in Medical/Surgical.

Medicare

Good Samaritan Hospital began reporting patients over 65 years of age during the last six months of 1983 and formally entered the Medicare Program in June, 1984. All of the hospitals in District IX now accept Medicare patients.

In 1983, 61.7% of all patient days in District IX were Medicare. Only six months of data are included in the Medicare utilization table for Good Samaritan Hospital. The average length of stay dropped from 1982-1983 from 9.0 days to 8.9 days and continues to drop during 1984.

Figure 10
1983 MEDICARE PATIENT DAYS AS A PERCENTAGE OF TOTAL PATIENT DAYS WITHIN EACH SUBDISTRICT

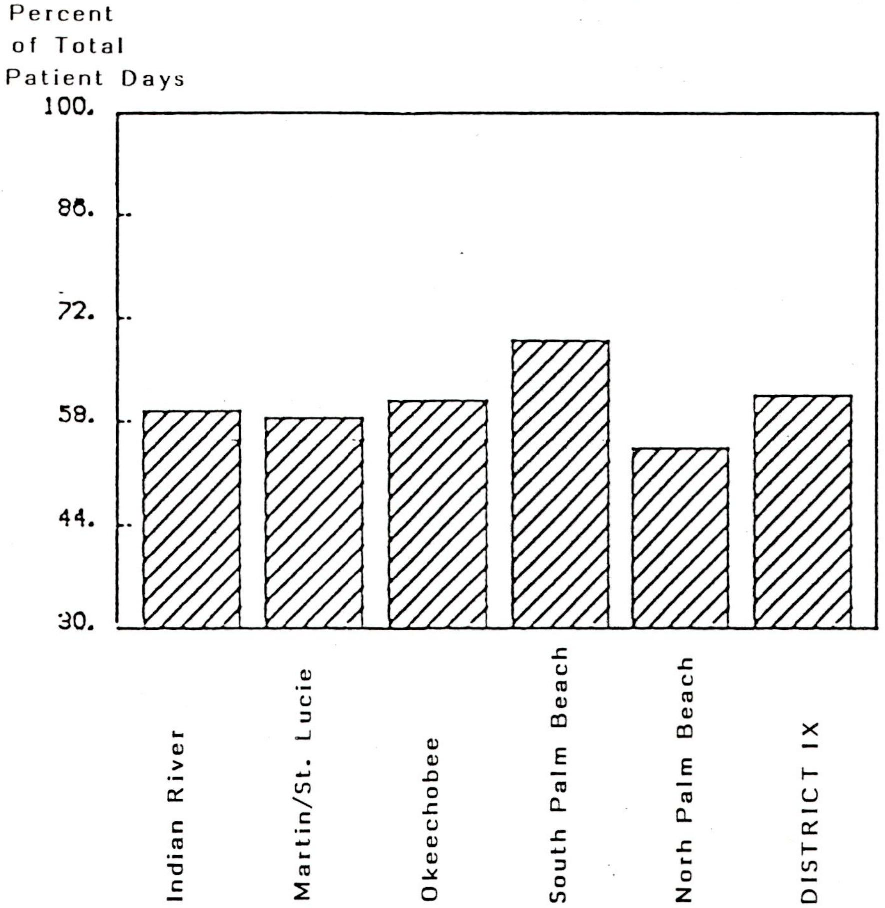


Figure 11
1983 TOTAL MEDICARE PATIENT DAYS
PROVIDED IN DISTRICT IX - BY SUBDISTRICT

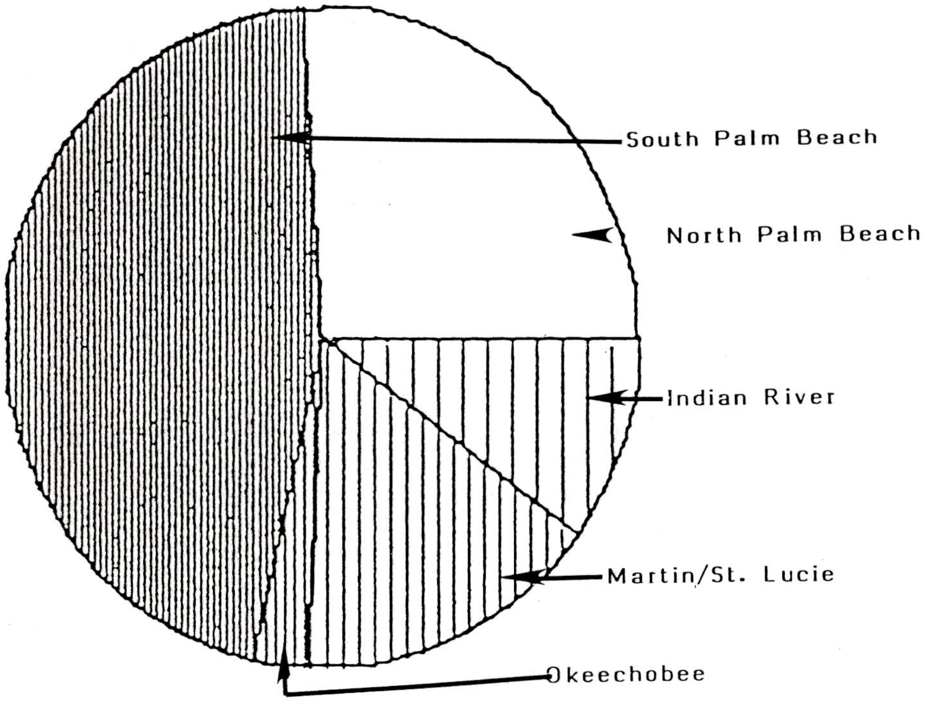


TABLE IX

1983 - ANNUAL MEDICARE DATA **

Area	Number of Admissions	Number of Patient Days	% of Total Patient Days	Length of Stay
Indian River Memorial Hospital	5,007	45,642	59.2	9.0
Humana Hospital Sebastian	1,642	14,942	60.3	9.1
Indian River County Subdistrict	**6,649**	**60,584**	**59.5**	**9.1**
Martin Memorial Hospital	6,194	50,772	60.5	8.2
Lawnwood Medical Center	3,846	39,829	55.7	10.4
Port St. Lucie Medical Center	362	3,305	61.5	9.1
Martin /St. Lucie Subdistrict	**10,402**	**93,906**	**58.4**	**9.0**
H.H. Raulerson, Jr. Memorial Hospital	1,762	16,092	61.1	9.1
Okeechobee Subdistrict	**1,762**	**16,092**	**61.1**	**9.1**
Bethesda Memorial Hospital	6,372	57,388	66.4	9.0
Boca Raton Community Hospital	9,027	89,519	72.7	9.9
Delray Community Hospital	3,794	28,806	76.4	7.7
Doctors Hospital	4,023	36,866	65.4	9.2
J. F. Kennedy Memorial Hospital	6,877	60,037	65.9	8.7
West Boca Raton Medical Center	----------	------UNOPENED	D----------	----------
South Palm Beach Subdistrict	**30,093**	**272,616**	**69.1**	**9.1**
Humana Hospital - Palm Beaches	3,689	36,298	74.1	9.8
Everglades Memorial Hospital	345	2,692	16.8	7.8
Glades General Hospital	427	3,451	21.9	8.1
Good Samaritan Hospital [a]	280	2,714	9.5	9.7
Palm Beach Gardens Medical Center	2,894	20,931	51.3	7.2
Palm Beach/Martin County Medical Center	2,785	23,400	60.7	8.4
St. Mary's Hospital	7,922	66,569	67.5	8.4
North Palm Beach Subdistrict	**18,342**	**156,055**	**54.3**	**8.5**
DISTRICT IX TOTAL	**67,248**	**599,253**	**61.7**	**8.9**

[a] Six Months Data, only.

** The Wellington Hospital Medical Center and the Palms West Community Hospital are not under construction and are not included in this table.

Medicaid

In 1983, 3.2% of all patient days provided to District IX consumers were Medicaid. This compares with 2.7% in 1981 and 1982. A total of 6,019 more Medicaid patient days were provided to District IX consumers in 1983 than in 1982. The average length of stay rose from 5.4 days in 1982 to 5.8 days in 1983. A few of the hospitals in District IX do not have Medicaid contracts and accept Medicaid patients on an emergency basis, only.

The following hospitals provided the Medicaid care in District IX:

TABLE X
PERCENT OF TOTAL MEDICAID PATIENT DAYS
PROVIDED IN DISTRICT IX
BY HOSPITAL - 1983

AREA	% of District
Indian River Memorial Hospital	6.2
Humana Hospital Sebastian	0.2
Indian River County Subdistrict	**6.5**
Martin Memorial Hospital	9.3
Lawnwood Medical Center	17.7
Port St. Lucie Medical Center	0.3
Martin/St. Lucie Subdistrict	**27.2**
H. H. Raulerson, Jr. Memorial Hospital	2.8
Okeechobee Subdistrict	**2.8**
Bethesda Memorial Hospital	6.3
Boca Raton Community Hospital	1.1
Delray Community Hospital	Insig.
Doctors Hospital	1.0
J. F. Kennedy Memorial Hospital	4.7
West Boca Raton Medical Center	--
South Palm Beach Subdistrict	**13.1**
Humana Hospital Palm Beaches	0.1
Everglades Memorial Hospital	14.5
Glades General Hospital	11.3
Good Samaritan Hospital	0.2
Palm Beach Gardens Medical Center	0.7
Palm Beach/MartinCounty Medical Center	0.0
St. Mary's Hospital	23.7
North Palm Beach Subdistrict	**50.5**
DISTRICT IX TOTAL	**100%**

Figure 12
1983 MEDICAID PATIENT DAYS AS A PERCENTAGE OF TOTAL PATIENT DAYS WITHIN EACH SUBDISTRICT

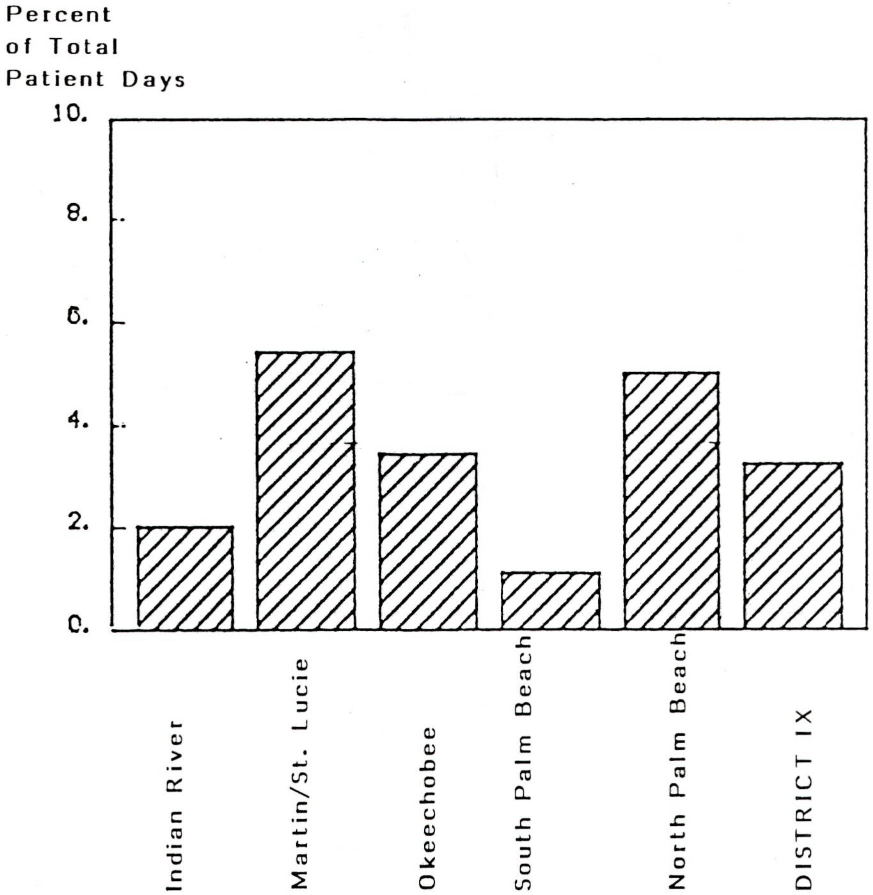


Figure 13
1983 TOTAL MEDICAID PATIENT DAYS
PROVIDED IN DISTRICT IX--BY SUBDISTRICT

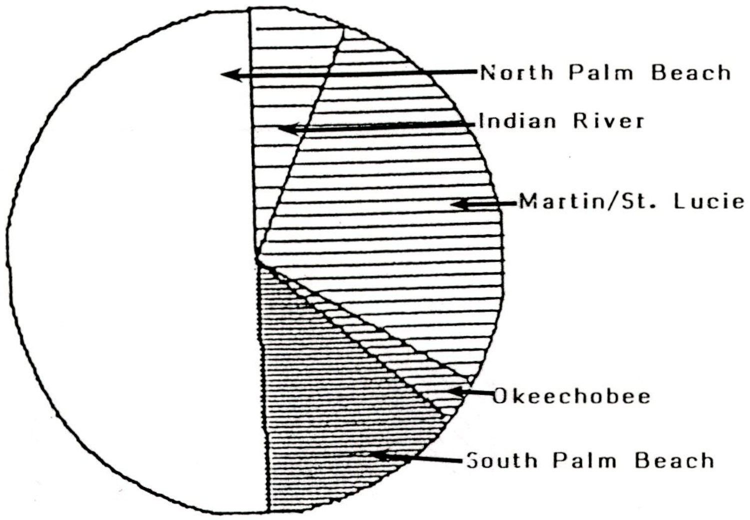


TABLE XI
1983 - ANNUAL
MEDICAID DATA**

Area	Number of Admissions	Number of Patient Days	% of Total Patient Days	Length of Stay
Indian River Memorial Hospital	424	1,993	2.6	4.7
Humana Hospital Sebastian	11	75	0.3	6.8
Indian River County Subdistrict	**435**	**2,068**	**2.0**	**4.8**
Martin Memorial Hospital	438	2,977	3.5	6.8
Lawnwood Medical Center	1,159	5,660	7.9	4.9
Port St. Lucie Medical Center	12	87	1.6	7.3
Martin /St. Lucie Subdistrict	**1,609**	**8,724**	**5.4**	**5.4**
H.H. Raulerson, Jr. Memorial Hospital	178	887	3.4	5.0
Okeechobee Subdistrict	**178**	**887**	**3.4**	**5.0**
Bethesda Memorial Hospital	399	2,026	2.3	5.1
Boca Raton Community Hospital	37	340	0.3	9.2
Delray Community Hospital	1	2	Insig.	2.0
Doctors Hospital	13	307	0.5	23.6
J. F. Kennedy Memorial Hospital	195	1,517	1.7	7.8
West Boca Raton Medical Center	----------------UNOPENED----------------			
South Palm Beach Subdistrict	**645**	**4,192**	**1.1**	**6.5**
Humana Hospital - Palm Beaches	3	29	0.1	9.7
Everglades Memorial Hospital	948	4,641	28.9	4.9
Glades General Hospital	419	3,629	23.0	8.7
Good Samaritan Hospital	16	67	0.1	4.2
Palm Beach Gardens Medical Center	22	209	0.5	9.5
Palm Beach/Martin County Medical Center	0	0	--	--
St. Mary's Hospital	1,288	7,591	7.7	5.9
North Palm Beach Subdistrict	**2,696**	**16,166**	**5.0**	**6.0**
DISTRICT IX TOTAL	5,563	32,037	3.2	5.8

**The Wellington Hospital Medical Center and the Palms West Community Hospital are not under construction and are not included in this table.

TABLE XII
DISTRICT IX COMPARATIVE MEDICAID STATISTICS
1982-1983

AREA	Admissions			Patient Days			Percent of Total Patient Days		ALOS	
	1982	1983	% Change	1982	1983	% Change	1982	1983	1982	1983
Indian River Memorial Hospital	378	424	+ 12.2	1,322	1,993	+ 50.8	1.7	2.6	3.5	4.7
Humana Hospital Sebastian	1	11	+1000.0	5	75	+1400.0	0.02	0.3	5.0	6.8
Indian River County Subdistrict	**379**	**435**	**+ 14.8**	**1,327**	**2,068**	**+ 55.8**	**1.3**	**2.0**	**3.5**	**4.8**
Martin Memorial Hospital	308	438	+ 42.2	1,876	2,977	+ 58.7	2.3	3.5	6.1	6.8
Lawnwood Medical Center	819	1,159	+ 41.5	4,336	5,660	+ 30.5	6.0	7.9	5.3	4.9
Port St. Lucie Medical Center	--	--	--	--	--	--	--	--	--	--
Martin/ St. Lucie Subdistrict	**1,127**	**1,597**	**+ 41.7**	**6,212**	**8,637**	**+ 39.0**	**4.1**	**5.6**	**5.5**	**5.4**
H. H. Raulerson, Jr. Memorial Hospital	155	178	+ 14.8	740	887	+ 19.9	2.9	3.4	4.8	5.0
Okeechobee Subdistrict	**155**	**178**	**+ 14.8**	**740**	**887**	**+ 19.9**	**2.9**	**3.4**	**4.8**	**5.0**
Bethesda Memorial Hospital	301	399	+ 32.6	1,483	2,026	+ 36.6	1.6	2.3	4.9	5.1
Boca Raton Community Hospital	37	37	0.0	320	340	+ 6.3	0.3	0.3	8.6	9.2
Delray Community Hospital	--	--	--	--	--	--	--	--	--	--
Doctors Hospital	11	13	+ 18.2	103	307	+ 198.1	0.2	0.5	9.4	23.6
J. F. Kennedy Memorial Hospital	155	195	+ 25.8	1,188	1,517	+ 27.7	1.3	1.7	7.7	7.8
West Boca Raton Medical Center	--	--	--	--	--	--	--	--	--	--
South Palm Beach Subdistrict	**504**	**644**	**+ 27.8**	**3,094**	**4,190**	**+ 35.4**	**0.8**	**1.2**	**6.1**	**6.5**
Humana Hospital Palm Beaches	6	3	- 50.0	23	29	+ 26.1	0.06	0.1	3.8	9.7
Everglades Memorial Hospital	783	948	+ 21.1	3,694	4,641	+ 25.6	23.5	28.9	4.7	4.9
Glades General Hospital	281	419	+ 49.1	2,098	3,629	+ 73.0	15.8	23.0	7.5	8.7
Good Samaritan Hospital	0	16	--	0	67	--	--	0.1	--	4.2
Palm Beach Gardens Medical Center	21	22	+ 4.8	160	209	+ 30.6	0.4	0.5	7.6	9.5
Palm Beach/Martin County Medical Center	0	0	--	0	0	--	--	--	--	--
St. Mary's Hospital	1,586	1,288	- 18.8	8,670	7,591	- 12.4	8.3	7.7	5.5	5.9
North Palm Beach Subdistrict	**2,677**	**2,696**	**+ 0.7**	**14,622**	**16,166**	**+ 10.6**	**4.5**	**5.0**	**5.5**	**6.0**
DISTRICT IX TOTAL	4,842	5,550	+ 14.6	26,018	31,948	+ 22.8	2.7	3.3	5.4	5.8

Please Note: Only those hospitals open for all of 1982 and 1983 are utilized in this comparison.

Indigent Patients

In July, 1983, the Council began to request data on indigent patients not covered by Medicaid. The lack of data is apparent and improvement in this reporting mechanism is needed.

TABLE XIII

CHARITY PATIENTS: JULY - DECEMBER, 1983

Key: N/A = Not Applicable
N/AV = Not Available
N/R = Not Reporting

Hospital	Hill-Burton Admissions	Hill-Burton Patient Days	Other than Hill-Burton Admissions	Other than Hill-Burton Patient Days
Indian River Memorial Hospital	62	124	758	19,496
Humana Sebastian	N/A	N/A	N/A	N/A
Martin Memorial Hospital	46	232	10	47
Lawnwood Medical Center	N/A	N/A	N/A	N/A
Port St.Lucie Hospital[a]	N/R	N/R	N/R	N/R
H.H. Raulerson, Jr. Memorial Hospital	-0-	-0-	N/Av	N/Av
Bethesda Memorial Hospital	-0-	-0-	348	1,575
Boca Raton Community Hospital[b]	-0-	-0-	3	50
Delray Community Hospital[c]	-0-	-0-	67	429
Doctors Hospital	N/R	N/R	N/R	N/R
J.F. Kennedy Memorial Hospital	26	491	-0-	-0-
Humana Palm Beaches	N/A	N/A	N/A	N/A
Everglades Memorial Hospital	N/Av	N/Av	N/Av	N/Av
Glades General Hospital	64[d]	N/Av	N/Av	N/Av
Good Samaritan Hospital[e]	N/A	N/A	2	2
Palm Beach Gardens Medical Center	N/Av	N/Av	N/Av	N/Av
Palm Beach/Martin County Medical Center	N/A	N/A	N/A	N/A
St. Mary's Hospital	-0-	-0-	18	N/Av

Please Note: Indigent program participation is inclusive of an individual hospital's internal charitable programs and/or government sponsored programs.

[a] Opened September 21, 1983.

[b] September - December, only.

[c] Includes June

[d] October - December, includes county welfare.

[e] October and November, only.

Specialty Services Utilization

Radiation Therapy

Presently, four hospitals in District IX report radiation therapy statistics to this Council.

1983 RADIATION THERAPY TREATMENTS

	Linear Accelerators		Other Units	
Hospital	Unduplicated Count of Patients Receiving Treatment	Number of Treatment Sessions	Unduplicated Count of Patients Receiving Treatment	Number of Treatment Sessions
Lawnwood Medical Center	N/R	13,522	--	--
Boca Raton Community Hospital	873	18,104	26	414
Good Samaritan Hospital	1,323	12,745	93	557
St. Mary's Hospital	--	--	1,469	20,415

Please Note: *Lawnwood has one linear accelerator, Boca Raton and Good Samaritan each have two units. The other units include cobalt, orthovoltage and superficial machines.*

Certificate of Need approved radiation therapy units consist of:

CON #2549: Martin Memorial Hospital - purchase of one linear accelerator.

CON #2265: Lawnwood Medical Center - Purchase of one additional linear accelerator.

CON #2255: Bethesda Memorial Hospital - construction of a Radiation Therpay Unit to accomodate 2 linear accelerators.

CON #2673: J F Kennedy Health Institute - Oncology andRadiation Therapy Center - to include the purchase of 1 linear accelerator

CON #2835: Palm Beach/Martin County Medical Center - purchase of 1 linear accelerator

CON #3161: St.Mary's Hospital - purchase of 1 linear accelerator

CT Scans

The following hospitals report statistics on computerized axial tomography scanners to this Council:

CT SCANNERS

TABLE XIV

1983 CT SCANS

Key: N/R = Not Reporting

Hospital	Full Body Scanner			Head Scanner		
	Units	Patients	Scans	Units	Patients	Scans
Indian River Memorial Hospital	1	2,888	2,888	--	--	--
Humana Sebastian[a]	1	675	731	--	--	--
Martin Memorial Hospital	1	2,254	2,254	--	--	--
Lawnwood Medical Center	1	N/R	1,510	--	--	--
H.H. Raulerson, Jr. Memorial Hospital[b]	1	N/R	69	1	N/R	56
Bethesda Memorial Hospital	--	--	--	--	--	--
Boca Raton Community Hospital	1	7,510	7,510	--	--	--
Delray Community Hospital	1	742	742	--	1,091	1,091
Doctors Hospital *	--	1,837	850	--	c	1,079
J.F. Kennedy Memorial Hospital	1	1,975	1,975	--	3,150	3,150
Humana Palm Beaches*[d]	--	591	626	--	790	808
Everglades Memorial Hospital	--	--	--	--	--	--
Glades General Hospital	--	--	--	--	--	--
Good Samaritan Hospital	1	1,732	1,909	1	1,520	2,022
Palm Beach Gardens Medical Center	N/R	N/R	N/R	N/R	N/R	N/R
Palm Beach/Martin County Medical Center *	--	1,577	1,842	--	--	--
St. Mary's Hospital	N/R	N/R	N/R	N/R	N/R	N/R

Please Note: A Scan is defined as a series of passes, regardless of the number of passes per Scan. Pre- and post-scans should be counted separately.

**Share a Mobile Unit.*

[a] *Data includes May - December, only.*

[b] *Data includes October - December, only.*

[c] *Included in full body patients*

[d] *January data not available.*

Certificate of Need Approvals include:

CON #2575: Martin Memorial Hospital - replacement of existing CT system.

CON #2636: Lawnwood Medical Center - Replace and update existing whole body CT Scanner.

CON #2709: Bethesda Memorial Hospital - replacement of existing CT Scanner.

CON #2813: Good Samaritan Hospital - replace whole body CT Scanner.

CON #2411: Humana Hospital Palm Beaches - purchase in-house CT Scanner so that the hospital will no longer need the mobile unit.

Cardiac Catheterization and Open Heart Surgery

Palm Beach Gardens Medical Center is the only hospital presently operating a cardiac catheterization laboratory in District IX. It is also the only hospital that is operating an open heart surgery program.

Certificate of Need approved programs consist of:

CON #2672: Delray Community Hospital - Cardiac Catheterization Laboratory and Open Heart Surgery.

CON #2675: J. F. Kennedy Health Institute - Cardiac Catheterization Laboratory.

CON #3073: J. F. Kennedy Health Institute - establish Open Heart Surgery Program.

CARDIAC CATHETERIZATION PROCEDURES

Month	*1982*	*1983*
January	*0*	*33*
February	*0*	*31*
March	*3*	*28*
April	*13*	*19*
May	*17*	*34*
June	*22*	*22*
July	*24*	*31*
August	*16*	*21*
September	*18*	*23*
October	*21*	*32*
November	*22*	*24*
December	*24*	*27*
TOTAL	*180*	*325*

The Open Heart Surgery program began in Palm Beach Gardens Medical Center in November of 1983. For the months of November and December, seven procedures were performed.

Ambulatory Care

The following table illustrates ambulatory care visits by hospital for District IX. It should be noted that all triage patients have not been included in the total ER visits so the figures may be slightly low.

TABLE XV

AMBULATORY CARE

Key: N/R = Not Reported

Hospital	Number of Ambulatory ER Visits	Number of ER Patients Admitted	Total ER Visits	Number of Visits to Organized Outpatient Departments (Excluding ER Visits)
Indian River Memorial Hospital	21,616	3,758	25,037	--
Humana Sebastian	4,228*	1,254	5,482	2,467
Martin Memorial Hospital	27,329	4,490	31,819	2,057
Lawnwood Medical Center	21,537	5,208	26,878	21,018
Port St. Lucie Hospital[a]	1,568*	417	1,985	792
H.H. Raulerson, Jr. Memorial Hospital	9,070	1,717	10,980	4,513
Bethesda Memorial Hospital	19,114*	4,178	23,292	10,344
Boca Raton Community Hospital	23,060	5,735	28,795	25,802
Delray Community Hospital	9,257	2,156	11,115	6,013[b]
Doctors Hospital	16,089	3,053	19,142	6,570
J.F. Kennedy Memorial Hospital	24,759	4,360	29,115	11,022
Humana Palm Beaches	4,280*[c]	1,768[c]	6,632	3,657[c]
Everglades Memorial Hospital	5,141*	653	5,794	4,940
Glades General Hospital	11,686	1,475	13,161	--
Good Samaritan Hospital	23,625	2,755	26,380	16,996
Palm Beach Gardens Medical Center	11,123*	2,123	13,246	6,492
Palm Beach/Martin County Medical Center	9,099	1,454	10,426	22,232
St. Mary's Hospital	14,735*	3,568	18,303	N/R
TOTAL	257,316	50,112	307,582	144,915

*Estimate

[a] Data for October - December

[b] February Data not available

[c] January Data not available

Service Areas

Based on the protocols for defining acute care general hospital subdistricts, District IX will have five (5) subdistricts:

1. *Indian River County*
2. *Okeechobee County*
3. *Martin/St. Lucie County*
4. *Northern Palm Beach County*
5. *Southern Palm Beach County*

Indian River and Okeechobee are rural subdistricts. Currently, there are two acute care hospitals in Indian River County (Indian River Memorial Hospital and Sebastian River Medical Center.) H. H. Raulerson, Jr. Memorial Hospital is the only acute care facility presently in Okeechobee County.

Effective June 30, 1983, Martin and St. Lucie Counties combined became a Metropolitan Statistical Area (MSA). With the opening of the Port St. Lucie Medical Center, there are presently three hospitals servicing this subdistrict. Martin Memorial Hospital is located in Stuart and Lawnwood Medical Center is in Ft. Pierce.

The accompanying maps of Palm Beach County illustrate the subdistrict division. The two subdistricts are separated roughly at Southern Boulevard and the Loxahatchee Wild Life Refuge to the west. Population zones are noted on these maps, as well as census tracts for the Glades area. In 1980, the North Palm Beach Subdistrict had a population of 232,313 and the South Palm Beach Subdistrict had a population of 344,500.

Two problems encountered in the subdistricting of Palm Beach County for Long Term Care resurfaced in the planning for Acute Care Hospitals. First of all, the western portion of Palm Beach County around Lake Okeechobee should not be included with the coastal area. This very rural region has far different needs than the rest of Palm Beach County. This agricultural region has severe accessibility problems to the eastern portion of the County due to poor roadways and the lack of east-west transportation systems. However, the western area did not qualify for its own subdistrict and, therefore, has been included in the northern subdistrict.

The second problem involves an area west of West Palm Beach. Once again, the original population zones created a problem in that Royal Palm Beach and Wellington have been split. Royal Palm Beach falls into the northern subdistrict while Wellington is included in the southern subdistrict. In fact, these municipalities are not only adjacent to each other, but also share a variety of services and facilities.

Most of the tables and charts within this plan have the hospitals grouped by subdistrict in order to facilitate subdistrict comparison. The 1980 Population by Subdistrict is included in Table XX.

FIGURE 14

PALM BEACH COUNTY
ACUTE CARE SUBDISTRICTS AND POPULATION ZONES

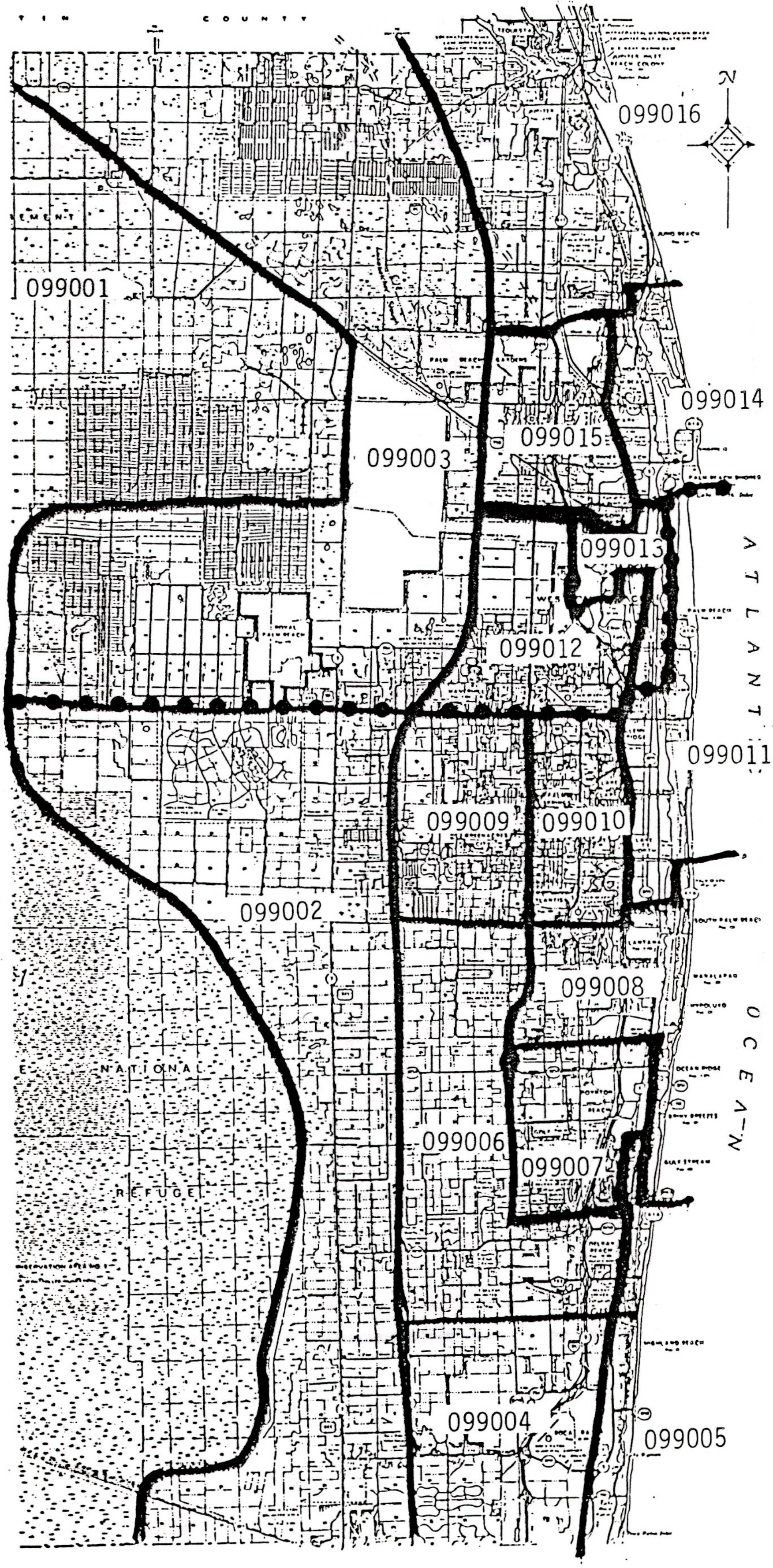
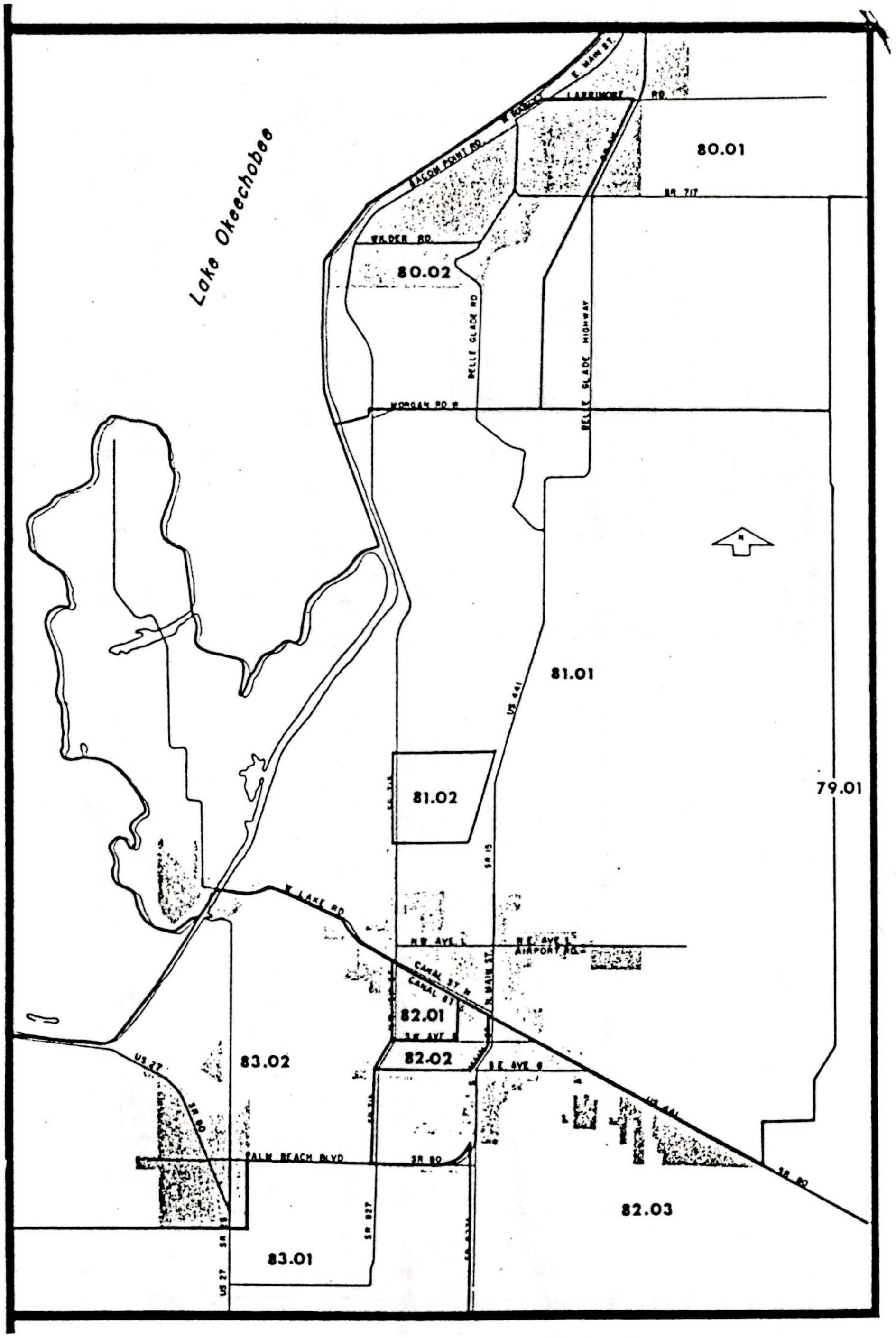


FIGURE 15

GLADES AREA (NORTHERN PALM BEACH SUBDISTRICT)

BY CENSUS TRACTS

POPULATION ZONE 099001



Unique Needs of District IX

The acute hospital bed need in District IX is strongly affected by several factors in addition to and in conjunction with factors identified in the State Bed Need Methodology. These factors include a rapidly growing population with a very large elderly segment, tremendous seasonal fluctuation, and chronic disease and mortality rates that are higher than the Florida and National averages. Patient flow in and out of District IX facilities is a significant issue, especially in hospitals adjacent to the district boundaries. Each of these factors must be considered in the allocation of future acute care beds.

The current acute care bed need methodology does not weigh these criteria heavily enough for District IX. Although the methodology may be correct for the State as a whole, it does not deal fairly with the crucial and unique needs of District IX.

Population

The projected growth in population in District IX during the 1980s is tremendous. From 1980 to 1990, the five county area should experience more than a 49% increase, while the State of Florida is projected to grow approximately 30%. Within each individual county, St. Lucie County is projected to have the largest percentage growth in District IX from 1980-1990 (+63.8%). In terms of actual numbers, Palm Beach County will gain the greatest number of new residents in District IX from 1980-1990. Table XVI details growth within counties utilizing the standard medium range projections.

TABLE XVI
PROJECTED POPULATION GROWTH - MEDIUM
1980-1985 1980-1990

County	*1980 Estimates*	*1985 Projections*	*% Change 1980-85*	*1990 Projections*	*% Change 1980-1990*
Indian River	*59,896*	*75,800*	*+26.6%*	*92,400*	*+54.3%*
Martin	*64,014*	*81,800*	*+27.8%*	*100,900*	*+57.6%*
Okeechobee	*20,264*	*24,500*	*+20.9%*	*28,500*	*+40.6%*
Palm Beach	*576,863*	*706,600*	*+22.5%*	*840,500*	*+45.7%*
St. Lucie	*87,182*	*115,600*	*+32.6%*	*142,800*	*+63.8%*
District IX	***808,219***	***1,004,300***	***+24.3%***	***1,205,100***	***+49.1%***
State of Florida	***9,746,324***	***11,195,600***	***+14.9%***	***12,623,900***	***+29.5%***

Source: University of Florida, Bureau of Economic and Business Research, Bulletin 68, April 1984; 1980 Census.

Table XVII details the high range projections since there is a possibility that even more rapid growth may occur during this time frame.

TABLE XVII
PROJECTED POPULATION GROWTH - HIGH
1980-1985 1980-1990

County	1980 Estimates	1985 Projections	% Change 1980-85	1990 Projections	% Change 1980-1990
Indian River	59,896	80,400	+34.2%	103,500	+72.8%
Martin	64,014	86,700	+35.4%	113,000	+76.5%
Okeechobee	20,264	26,000	+28.3%	32,000	+57.9%
Palm Beach	576,863	734,900	+27.4%	907,700	+57.4%
St. Lucie	87,182	120,300	+38.0%	154,300	+77.0%
District IX	**808,219**	**1,048,300**	**+29.7%**	**1,310,500**	**+62.1%**
State of Florida	**9,746,324**	**11,422,100**	**+17.2%**	**13,097,800**	**+34.4%**

Source: University of Florida, Bureau of Economic and Business Research, Bulletin 68, April 1984; 1980 Census.

Table XVIII illustrates the growth of individual counties as a percentage of the total District growth from 1980-1990.

TABLE XVIII
PROJECTED POPULATION GROWTH BY COUNTY OF TOTAL DISTRICT GROWTH, 1980-1990

County	Medium		High	
	# Change	% Change	# Change	% Change
Indian River	32,504	8.2%	43,604	8.7%
Martin	36,886	9.3%	48,986	9.8%
Okeechobee	8,236	2.1%	11,736	2.3%
Palm Beach	263,637	66.4%	330,837	65.9%
St. Lucie	55,618	14.0%	67,118	13.4%
District IX	**396,881**	**100.0%**	**502,281**	**100.0%**

Source: University of Florida, Bureau of Economic and Business Research, Bulletin 68, April 1984; 1980 Census.

Table XIX gives the 1989 projected population growth figures that are utilized by the State in their acute care planning methodology.

TABLE XIX
STATE PROJECTED POPULATION GROWTH FOR
DISTRICT IX BY AGE GROUP
1989

County	*0-64*	*65+*	*Totals*
Indian River			
Martin			
Okeechobee			
Palm Beach			
St. Lucie			
District IX			

Source: State Data, Tallahassee, July, 1984.

Figure 16 graphically depicts the projected medium range growth for each county in District IX.

Figure 16
DISTRICT IX MEDIUM POPULATION PROJECTIONS BY COUNTY

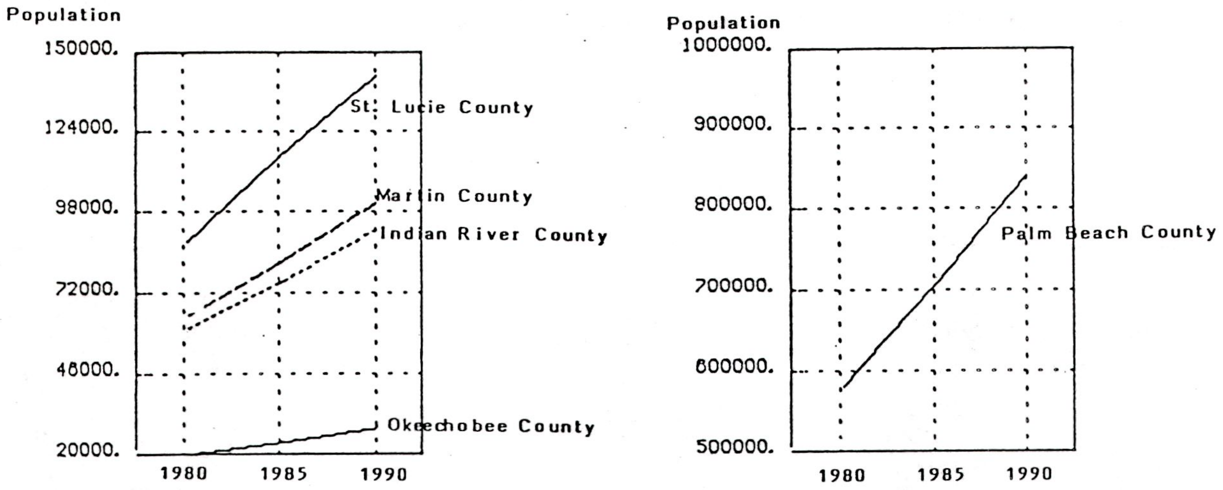


Table XX gives estimates of the 1983 population as well as the percent increase since the 1980 Census. In the past three years, District IX has seen more than a 14% increase in population.

TABLE XX
DISTRICT IX 1983 POPULATION ESTIMATES

Area	*1983*	*% Change Since 1980 Census*
Indian River Subdistrict	**69,414**	**+15.9%**
Martin County	*74,143*	*+15.8%*
St. Lucie County	*105,224*	*+20.7%*
Martin/St. Lucie Subdistrict	**179,367**	**+18.6%**
Okeechobee Subdistrict	**22,867**	**+12.8%**
North Palm Beach Subdistrict	**N/A**	—
South Palm Beach Subdistrict	**N/A**	—
Palm Beach County Total	*652,562*	*+13.1%*
District IX	**924,210**	**+14.4%**

Source: University of Florida, Bureau of Economic & Business Research, Bulletin 68, April, 1984.

The elderly population in District IX will have increased from 22.2% of the total population in 1980 to 27.4% by 1990. Traditionally, Martin and Palm Beach Counties have had the largest percentage of elderly residents and this trend will continue indefinitely. Table XXI indicates the age breakdown by acute care subdistrict within District IX. The elderly segment of any population naturally has a much higher hospitalization rate and length of stay than the population as a whole. Because of the increasingly large segment of elderly residents in District IX, area hospitals are placed under additional strain.

TABLE XXI
DISTRICT IX AGE BREAKDOWN
1980 CENSUS

Area	*0-64*	*65+*	*0-14*	*15-44 Females*	*Subtotal*
Indian River Subdistrict	**47,716**	**12,180**	**10,812**	**10,846**	**59,896**
Martin County	*48,360*	*15,654*	*10,517*	*11,658*	*64,014*
St. Lucie County	*72,385*	*14,797*	*18,846*	*17,289*	*87,182*
Martin/St. Lucie Subdistrict	**120,745**	**30,451**	**29,363**	**28,947**	**151,196**
Okeechobee Subdistrict	**17,813**	**2,451**	**5,146**	**4,133**	**20,264**
North P.B. Co. Subdistrict*	**190,749**	**41,564**	**N/A**	**N/A**	**232,313**
South P.B. Co. Subdistrict*	**251,612**	**92,888**	**N/A**	**N/A**	**344,500**
Palm Beach Co. Total	*442,411*	*134,452*	*98,328*	*108,357*	*576,863*
District IX	**628,685**	**179,534**	**143,649**	**151,668**	**808,219**

**These figures represent 50 less individuals than in the original census data due to January, 1983 revision.*

TABLE XXII
1983 TOURISM FIGURES

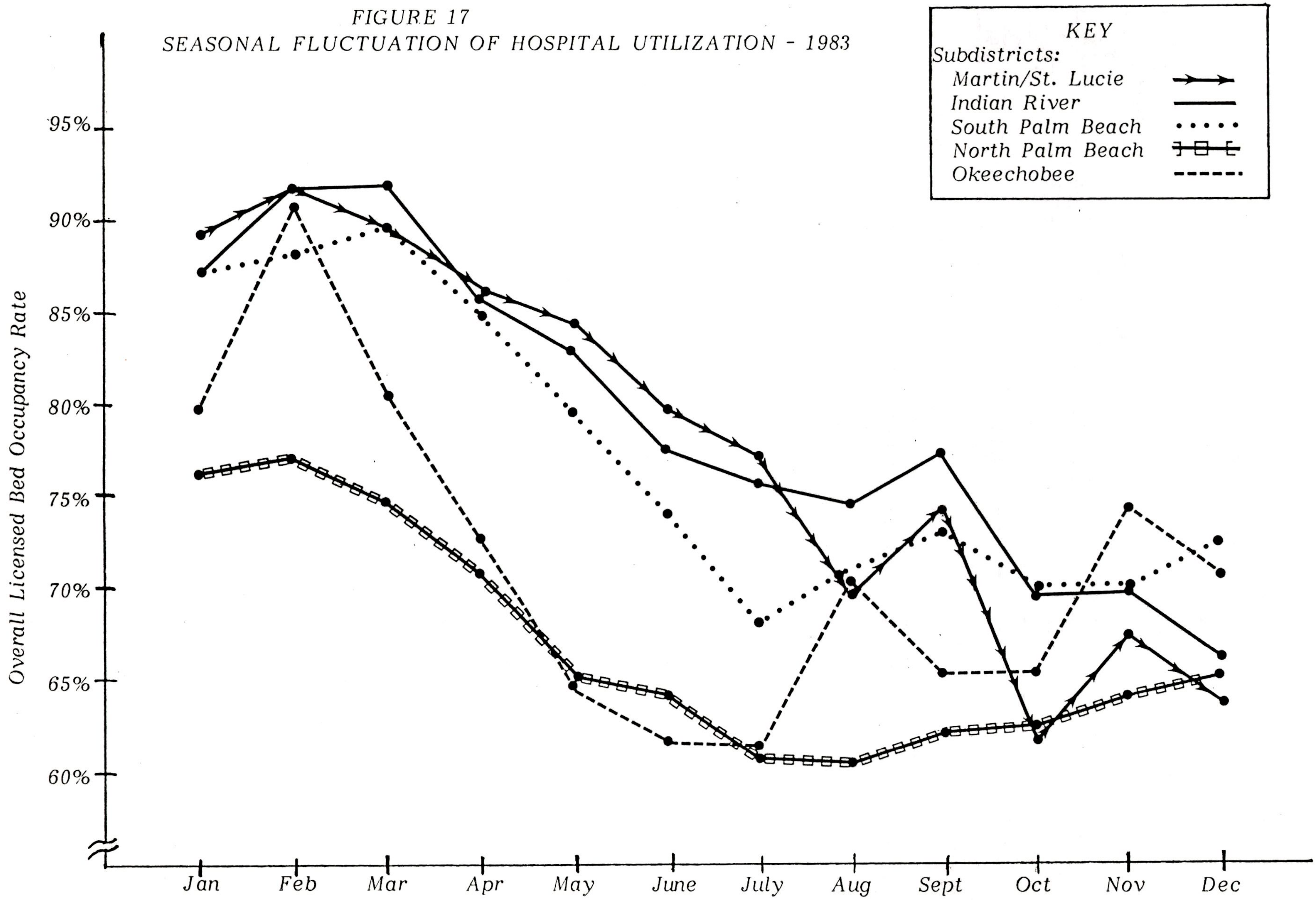
County	Air	Auto	Total	% of District
Palm Beach	1,395,893	812,488	2,208,381	62.8%
Indian River	256,230	273,368	529,598	15.1%
Martin	53,673	268,546	322,219	9.2%*
St. Lucie	97,117	245,256	342,373	9.7%*
Okeechobee	8,694	103,745	112,439	3.2%
District IX	**1,811,607**	**1,703,403**	**3,515,010**	**100.0%**

*Martin/St. Lucie Total = 18.9%

Definition: All non-Florida residents who stay in Florida more than one night (includes snowbirds). These figures do not include international travel.

Source: Division of Tourism, Departmentof Commerce, Tallahassee

FIGURE 17
SEASONAL FLUCTUATION OF HOSPITAL UTILIZATION - 1983

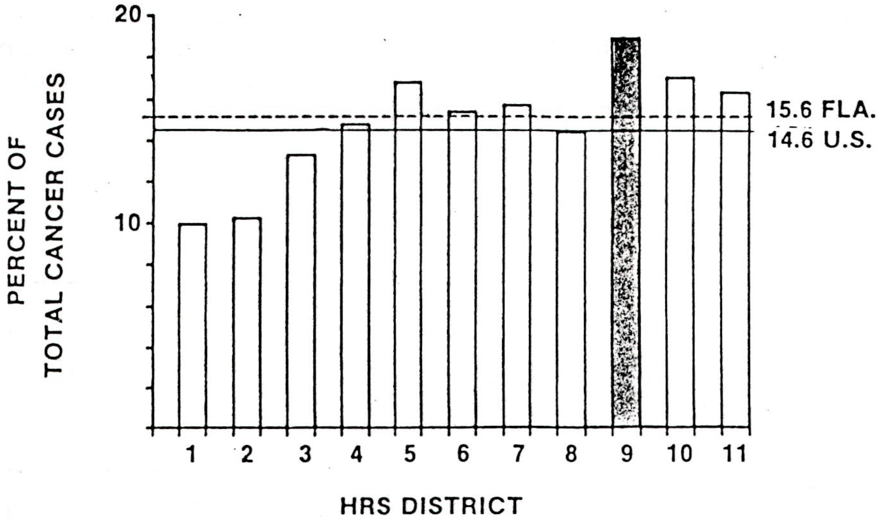


HEALTH FACTORS

In addition to the health factors discussed in the Health Profile Component of this Plan, District IX appears to have the highest percentages of colon-rectal and breast cancer within the State by HRS District. Colon-rectal cancer is the second most common cancer in Florida, followed by breast cancer. Skin cancer is the most common cancer in the Sunshine State.

Figure 18

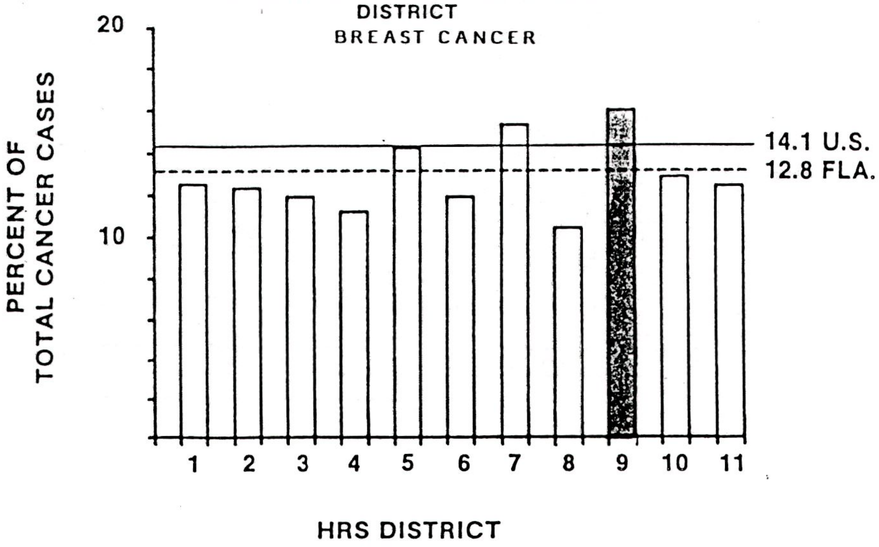
PERCENT OF TOTAL CASES BY HRS DISTRICT
COLON-RECTAL CANCER



Source: Florida Cancer Data System, University of Miami, School of Medicine, 1981

Figure 19

PERCENT OF TOTAL CASES BY HRS DISTRICT
BREAST CANCER



Source: Florida Cancer Data System, University of Miami, School of Medicine, 1981.

PATIENT ORIGIN

In 1980. the zip codes of discharged patients from hospitals within the five county area were tabulated. Based on this survey, patient flow from one subdistrict to another and patient flow from outside the District can be noted. It is obvious that hospitals which provide care to patients from other areas have additional burdens placed upon them. This fact must be taken into account when additional bed need is determined and allocated.

Table XXIII indicates the percentage of patients discharged from hospitals by the county of residence. The "Outside District" column is of particular interest. At Sebastian River Medical Center, located in northern Indian River County, over 30% of patients were from outside the District. At the southern end of Palm Beach County, Boca Raton Community Hospital received 26.5% of its patients from outside the District. Hence, facilities located near district boundaries can always be expected to receive a large number of patients from the neighboring district. This is yet another factor that must be considered when bed need is calculated.

TABLE XXIII
DISTRICT IX

PATIENT ORIGIN -- BY COUNTY
FEBRUARY AND AUGUST, 1980

Area	Palm Beach County	Indian River County	Martin County	Okee-chobee County	St. Lucie County	Outside District	Un-known
Indian River Memorial Hospital	--	78.8%	0.1%	3.2%	14.0%	1.8%	2.1%
Sebastian River Medical Center	--	68.5%	--	0.5%	0.7%	30.3%	--
Indian River Subdistrict	**—**	**76.8%**	*****	**2.6%**	**11.2%**	**7.7%**	**1.7%**
Martin Memorial Hospital	1.8%	0.8%	70.0%	1.5%	20.0%	5.9%	--
Lawnwood Medical Center	0.2%	1.9%	1.0%	5.0%	89.9%	2.0%	--
Martin/St. Lucie Subdistrict	**1.1%**	**1.3%**	**36.0%**	**3.2%**	**54.4%**	**4.0%**	**—**
H.H. Raulerson, Jr. Memorial Hospital	0.2%	0.2%	0.4%	91.0%	0.2%	8.0%	--
Okeechobee Subdistrict	**0.2%**	**0.2%**	**0.4%**	**91.0%**	**0.2%**	**8.0%**	**—**
Bethesda Memorial Hospital	94.0%	--	--	--	--	2.8%	3.2%
Boca Raton Community Hospital	72.2%	--	0.1%	--	--	26.5%	1.2%
Doctors Hospital	92.2%	--	--	0.1%	--	3.5%	4.2%
J.F. Kennedy Memorial Hospital	97.5%	--	--	0.3%	--	2.2%	0.0%
South Palm Beach Subdistrict	**88.4%**	**—**	*****	*****	**—**	**9.5%**	**2.1%**
Community Hospital of the Palm Beaches	94.9%	--	1.2%	--	--	1.8%	2.1%
Everglades Memorial Hospital	85.3%	--	1.1%	0.4%	--	5.3%	7.9%
Glades General Hospital	88.5%	--	--	0.2%	--	4.1%	7.2%
Good Samaritan Hospital	94.3%	*	0.8%	0.7%	0.4%	3.5%	0.3%
Palm Beach Gardens Community Hospital	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Palm Beach/Martin County Medical Center	80.1%	0.7%	13.9%	0.4%	0.6%	3.4%	0.9%
St. Mary's Hospital	94.0%	--	1.5%	1.0%	1.4%	1.9%	0.2%
North Palm Beach Subdistrict	**92.1%**	*****	**2.1%**	**0.7%**	**0.7%**	**3.0%**	**1.4%**

*Insignificant

DISTRICT IX ALLOCATION METHODOLOGY

OVERVIEW

Step One: *3 beds/1,000 for those under 65 years of age, projected five years into the future utilizing HRS population projections.*

Step Two: *the number of beds needed for the elderly projected five years into the future, determined by the utilization rate of the most current calendar year.*

Step Three: *the number of beds from net flow of elderly (net non-resident patient days minus outflow to other districts plus inflow from other districts AS DETERMINED BY HRS).*

Step Four: *add the totals from Steps One, Two and Three and scale down first to HRS total District IX allocation and then to each individual subdistrict based upon the percentage of allocation need.*

Allocation Adjustment: *Consideration should be given to applicants who can document seasonal impact in the particular subdistrict and any other relevant updated information, including sub-county data, relating to Steps One through Four.*

RATIONALE:

With the advent of the Medicare prospective reimbursement system, there is literally no way to estimate the magnitude of impact that this reimbursement mechanism will have on hospital admissions, occupancy rates, and average lengths of stay. Therefore, relying upon the national standard of 4 beds/1,000 population was not adequate. There is a need for an indicator based solely on utilization for the elderly. Since the reimbursement mechanism for non-Medicare patients has not changed, a resource based methodology has been utilized for this population group.

TABLE XXIV
STATE ESTIMATED POPULATION
FOR DISTRICT IX BY AGE GROUP
1983

Area	*0-64*	*65+*	*Totals*
Indian River Subdistrict			
Martin County			
St. Lucie County			
Martin/St. Lucie Subdistrict			
Okeechobee Subdistrict			
North Palm Beach Subdistrict			
South Palm Beach Subdistrict			
Palm Beach County			
District IX			

Source: State Data, Tallahassee, July, 1984

ALLOCATION METHODOLOGY APPLIED FOR 1989

Step One: *Allocate 3 beds/1000 for those residents under 65 years of age within each subdistrict according to HRS 1989 population projections.*

Subdistrict	*1989 Population under 65*	*3.0/ 1000*
Indian River		
Martin/St. Lucie		
Okeechobee		
North Palm Beach (43.1%)		
South Palm Beach (56.9%)		

Please Note: *According to 1980 Census Tract data as reported by the Palm Beach County Area Planning Board, the North Palm Beach Subdistrict had 40.3% of the total county population and South Palm Beach had the remaining 59.7%. Of the under 65 population, North Palm Beach had 43.1% of the county and South Palm Beach had 56.9%. Of the over 65 population, North Palm Beach had 30.9% of the population and South Palm Beach had 69.1%. Due to the lack of subcounty data, we are forced to utilize these percentages.*

Step Two: *In order to get utilization rates for the 65 and over population, we need to subtract out the patient days delivered to the out-of-District residents and utilize the Medicare data as an estimate of patient days.*

Subdistrict	*% in 1980 of Patients Discharged from Outside District IX**	*1980 Percentage Applied to 1983 Admissions*	*1983 ALOS*	*Patient Days Derived*
Indian River	*7.7*	*1,137*	*6.9*	*7,845*
Martin/St. Lucie	*4.0*	*941*	*6.8*	*6,399*
Okeechobee	*8.0*	*298*	*7.1*	*2,116*
North Palm Beach	*3.0*	*1,604*	*6.0*	*9,624*
South Palm Beach	*9.5*	*4,863*	*7.7*	*37,445*

**1980 HPC Patient Origin Study*

In 1983, 61.7% of all patient days were Medicare Patient Days in District IX. If we use this District average and subtract that percentage of days deliverd to Medicare patients out of the District from the Subdistrict's Medicare patient days, we get the following:

Subdistrict	***A*** *# of Medicare Patient Days Delivered to Out-of-District Residents*	***B*** *Total # of Medicare Patient Days Delivered*	*(B - A)*	*1983[1] Medicare Use Rate Per 1000*	*1989 Projected 65+ Population*	*1989 Medicare Patient Days*
Indian River						
Martin/St. Lucie						
Okeechobee						
NPB						
SPB						

---

[1] Latest DHRS 1983 Population Estimates are to be used.

The total District IX allocation is ________ for 1989. The 1989 HRS District population projection, for all ages, is ________. The overall use rate in District IX in 1983 was:

$$\frac{\text{No. of Patient Days}}{1000} = \frac{\text{1,004,684 (1983 total patient days)}}{\underline{\qquad\qquad}\text{(Latest DHRS 1983 population estimate)}}$$

This gives us a projected total of ________ patient days in 1989. At this rate ________ beds translates into a ________ occupancy rate.

From this, we can determine how many beds will be needed for Medicare/65+ residents.

Subdistrict	*1989 Beds Needed for Elderly at Above Occupancy Rate*
Indian River	
Martin/St. Lucie	
Okeechobee	
NPB	
SPB	

Step Three: *In 1989, according to HRS projections, the District net flow of elderly in and out of this District is -__________. If we allocate these patient days by the percentage of elderly within each subdistrict of the total district, and, using the same occupancy rate used in Step 2, then:*

Area	*1989 % Elderly*	*Patient Days Derived*	*Beds Subtracted From Totals*
Indian River S/D			
Martin/St. Lucie S/D			
Okeechobee S/D			
NPB S/D			
SPB S/D			
District IX			

Step Four: *First, add the totals from Steps, One, Two and Three.*

Subdistrict	*Step One*	*Step Two*	*Step Three*	*Total*
Indian River				
Martin/St. Lucie				
Okeechobee				
NPB				
SPB				

The District allocation from HRS is __________ and the above total equals __________, therefore, we will adjust downward to the HRS allocation.

AREA	*Total Above*	*% of District*	*% of State Allocation*	*#of Beds*
Indian River			↑	
Martin/St. Lucie			*Same as*	
Okeechobee			*% of*	
NPB			*District*	
SPB			↓	
District IX				

In order to stay within the limits of the HRS allocation, we must adjust gross need downward to net need so that existing and approved beds are taken into account.

Subdistricts	*Existing and Approved Beds*	*Gross Need*	*+/-*
Indian River	*410*		
Martin/St. Lucie	*761*		
Okeechobee	*101*		
North Palm Beach	*1,462*		
South Palm Beach	*1,793*		

There is a total net need for District IX of __________ beds (__________ - 4,545 = __________). Therefore, only the subdistricts that show a need for beds at this point, will be allocated beds under the net need adjustment.

Subdistricts	*% of Gross Need*	*% of Gross Need Applied to Net Need (Beds)*
Indian River		
Martin/St. Lucie		
Okeechobee		
North Palm Beach		
South Palm Beach		

* * * * * *

In addition, the above stated bed allocation methodology should not be construed as an "absolute" determination of bed need on a subdistrict by subdistrict basis for District IX. A Final Determination of bed need for this district can be made only upon full consideration of information and criteria contained in the following: (a) Applicable State laws, Rules, and Regulations and the State Health Plan, (b) District IX Board adopted Health Plan(s) to include supporting information relevant to a well informed CON decision's being made, (c) information contained in CON application as deemed complete by the Department of HRS, and (d) information presented at the public hearing, if requested, on the CON application.

PROGRAM GOALS

--The number of acute care hospital beds in District IX should be maintained at not less than four (4) beds per 1000 population.

--Individual area hospitals should initiate a concerted effort to eliminate excess bed capacity in Obstetrics, Pediatrics, and ICU/CCU and to reallocate these underutilized beds to Medical/Surgical.

--The overall annual licensed bed occupancy rate for acute care general hospitals in District IX should equal 75%.

--The overall annual licensed bed occupancy rate for the following bed categories should be as follows:

Medical/Surgical	75%
Obstetrical	65%
Pediatric	65%
ICU/CCU, Monitored & Intermediate Care	75%

RECOMMENDATIONS BY PRIORITY RANKING

In addition to the Acute Care Bed Need Methodology (Florida Administrative Code, Chapter 10-5, 11(23)), the District IX Health Council has established the following policies and Priorities which should be used concurrently in planning acute care hospital bed need and allocation:

I. A. The following subdistricts are identified for the purpose of allocating acute care hospital beds:

- ***a. Indian River County***
- ***b. Martin/St. Lucie County***
- ***c. Okeechobee County***
- ***d. Palm Beach County***
  - ***1. Northern Subdistrict (Includes Glades Area)***
  - ***2. Southern Subdistrict***

B. Glades Area: New applications in the Glades area should not be considered as competing applications with the Northern Subdistrict of Palm Beach County. Consideration should be given to patient flow patterns from neighboring Hendry County into the Glades area.

RATIONALE

The Glades area is defined as that portion of Western Palm Beach County comprising population zone 099001. Currently, this area is included with the northern subdistrict of Palm Beach county because it does not qualify as a subdistrict of its own. However, it would not be practical nor fair to compare the very rural Glades region with the highly developed urban coastal regions. The poor east-west highways and basic lack of transportation prohibits residents of the Glades area from utilizing services on the coast. Hence, their special needs should be addressed separately and distinctly from northern Palm Beach County. Furthermore, because Hendry County and western Palm Beach county are adjacent and are both very rural and somewhat isolated from the coastal areas, their needs should be considered concurrently. Many residents in both Hendry and the Glades visit the other for a variety of services including health care.

II. District IX Allocation Methodology:

Step One: 3 beds/1000 for those under 65 years of age, projected five years into the future utilizing HRS population projections.

Step Two: the number of beds needed for the elderly projected five years into the future, determined by the utilization rate of the most current calendar year.

Step Three: the number of beds from net flow of elderly (net non-resident patient days minus outflow to other districts plus inflow from other districts as DETERMINED BY HRS).

Step Four: add the totals from Steps One, Two and Three and scale down first to HRS total District IX allocation and then to each individual subdistrict based upon the percentage of allocation need.

Allocation Adjustment: Consideration should be given to applicants who can document seasonal impact in the particular subdistrict and any other relevant updated information, including sub-county data, relating to Steps One through Four.

Please Note: Refer to the "District IX Allocation Methodology" Section of this Plan, (Pages 43 through 46) for numerical formulas.

RATIONALE

With the advent of the Medicare prospective reimbursement system, there is literally no way to estimate the magnitude of impact that this reimbursement mechanism will have on hospital admissions, occupancy rates, and average lengths of stay. Therefore, relying upon the national standard of 4 beds/1000 population was not adequate. There is a need for an indicator based solely on utilization for the elderly. Since the reimbursement mechanism for non-Medicare patients has not changed, a resource based methodology has been utilized for this population group.

III. A. Before needed beds, as determined by Rule 10-5.11(23), may be approved, applicants requesting additional acute care beds should demonstrate that certain occupancy thresholds have been achieved relative to medical/surgical, obstetric, pediatric and ICU/CCU beds. The average annual occupancy rate (most recent calendar year) in the applying facility and its corresponding subdistrict average, should equal or exceed the following levels (inclusive of CON approved beds):

Medical/Surgical	75%
Obstetrical	65%
Pediatric	65%
ICU/CCU, Monitored & Intermediate Care	75%

B. **An individual area hospital should initiate a concerted effort to eliminate excess bed capacity in Obstetrics, Pediatrics, and ICU/CCU and to relocate these under-utilized beds to Medical/Surgical. This reallocation should occur if:**

--Obstetrical Occupancy is less than 55%;
--Pediatric Occupancy is less than 40%;
--ICU/CCU Occupancy is less than 60%.

This conversion should occur prior to adding additional beds except for unique situations or characteristics such as geographic hardships to patients in a service area.

RATIONALE

Under-utilized beds are expensive to the hospital and, ultimately, to the patient. Adding beds to an under-utilized hospital is not cost-efficient. Conversion of under-utilized beds not only saves money, but also provides space for needed services. Medical/Surgical beds are usually the type of highest demand. Hence, Obstetrical and Pediatric beds, with traditionally low occupancy rates, should be converted to Medical/Surgical before new licensed beds are requested.

IV. **Priority shall be given to area hospitals which can show a commitment to or an historical record of service to Medicaid/Indigent, Handicapped, and Underserved population groups.**

RATIONALE

In 1983, 3.1% of all patient days in District IX hospitals were Medicaid. In 1983, twelve of the eighteen existing hospitals had less than 3.1% Medicaid patient days. However, the level of hospital participation is highly dependent upon existing referral patterns and the total number of Medicaid/Indigent population within each hospital's service area. A hospital should not be penalized if it can document its commitment to the indigent population within its service area. This documentation should be provided by each hospital reporting Medicaid/Indigent patient days on the Council's Monthly Hospital Utilization Reports and in their CON applications to the State of Florida, Department of HRS. In conjunction with this requirement to insure a more equitable participation in the programs for Medicaid/Indigent, Handicapped, and Underserved population groups, a monitoring system should be established to protect these acute care facilities and to strive for reimbursement of cost.

V. Priority shall be given to those hospitals that make a concerted effort to expand their roles in respect to developing a quality EMS System for this region. Specifically, hospitals should be highly supportive of developing the following elements of a quality EMS System:

1. **Categorization of hospitals to determine the level of care each can provide.**
2. **Development of uniform treatment protocols to assure quality on-site and institutional care.**
3. **Development of inter-hospital transfer agreements among hospitals in order to assure all citizens of equal access to specialty or more definitive care with minimum interruptions in service, regardless of ability to pay.**

RATIONALE

Currently, all county EMS programs in District IX lack sufficient medical involvement and control to assure that all citizens within the region receive optimum continuity and uniform quality emergency care.

It is essential that hospitals address the following EMS needs:

1. Categorization of hospitals to determine the exact level of care each can provide and the categories of patients for whom each is most capable of providing quality emergency and definitive care. Certain hospitals should also be designated as Level III trauma centers.*

2. The development of uniform treatment protocols to assure quality on-site and institutional care and to determine when and where patients should be transferred to receive a higher level of care.

3. The development of inter-hospital transfer agreements which guarantee patient's access to specialty care, regardless of ability to pay. Transfers to specialty care centers must be assured with a minimum of interruptions and delays; i.e., quick transfers of patients with serious spinal injuries to a center which specializes in those injuries can mean the difference between full recovery or total disability for the remainder of a life span.

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*There are three levels of trauma centers as defined by the American College of Surgeons in the standards entitled "Hospital Resources for Optimal Care of the Injured Patient" and adopted into Florida Statutes. Level I is the highest level available and is awarded to teaching hospitals only. Level II requires most of the same services available as Level I but allows for services to be promptly available and not necessarily on the hospital campus. Level III requires services above the level of an excellent emergency room.

VI. Priority shall be given to applicants who can document cost containment practices in their facilities.

RATIONALE

Cost containment practices, such as sharing services with other area hospitals, enhances efficient resource utilization and helps to avoid duplication.

VII. All District IX hospitals should participate in the Health Council's monthly utilization reporting system in a timely fashion.

RATIONALE

Current utilization statistics from all hospitals are essential to the making of well informed CON decisions in District IX.

STATE OF FLORIDA
DEPARTMENT OF HEALTH AND REHABILITATIVE SERVICES
CHAPTER 10-5, FLORIDA ADMINISTRATIVE CODE
PROCEDURES FOR THE ADMINISTRATION OF SECTIONS 381.493-381.499, FLORIDA STATUTES, HEALTH FACILITIES AND HEALTH SERVICES PLANNING ACT
"CRITERIA AGAINST WHICH APPLICATIONS WILL BE JUDGED"
"ACUTE CARE BED NEED"

10-5.11(23) Acute Care Bed Need.

(a) Definitions.

1. Departmental Service District. Departmental service district means one of the service districts established for the Department of Health and Rehabilitative Services in Chapter 20.19, Florida Statutes.

2. State Health Planning Agency. State Health Planning Agency means the Office of Health Planning and Development within the Department of Health and Rehabilitative Services.

3. Local Health Councils. Local Health Councils means the comprehensive local health councils established by Chapter 381.493, Florida Statutes.

4. Urban Area. Urban area means a county designated as all or part of a Standard Metropolitan Statistical Area, as determined by the United States Bureau of the Census, and having 50,000 or more persons residing in one or more incorporated areas.

5. Rural Area. Rural area means a county not designated as all or part of a Standard Metropolitan Statistical Area, as determined by the United States Bureau of the Census, or a county so designated but having fewer than 50,000 persons residing in one or more incorporated areas.

(b) Departmental Goal. The Department will consider applications for acute care hospital beds in context with all applicable statutory and rule criteria. The Department will not normally approve applications for new or additional acute care hospital beds in any departmental service district if approval of an application would cause the number of beds in that district to exceed the number of beds calculated to be needed according to the methodology included in paragraphs (f), (g) and (h) below. A favorable Certificate of Need determination may be made when the criteria, other than bed need, as provided for in Chapter 381.494(6)(c), Florida Statutes, demonstrate need. An unfavorable Certificate of Need determination may be made when a calculated bed need exists but other criteria specified in Chapter 381.494(6)(c), Florida Statutes, are not met.

(c) Scope of Need Methodology. The methodology included in paragraph (f) below addresses the need for general medical and surgical, intensive care, pediatric and obstetrical acute care services in hospitals holding general licenses. The determination of need for comprehensive rehabilitation, psychiatric and substance abuse services provided in hospitals holding general or specialty licenses is included in Chapter 10-5.11(24), (25), (26) and (27), Florida Administrative Code.

(d) Acute Care Service Subdistrict Designation. Acute care service subdistrict designations shall be adopted, as necessary, by each Local Health Council as an element of its local health plan according to guidelines developed by the State Health Planning Agency. Designations will become effective for the purposes of this rule upon the filing of the adopted local health plan acute care subdistricting elements with the Secretary of State.

(e) Subdistrict Bed Allocations. Subdistrict bed allocations by type of service shall be made by the Local Health Councils consistent with the district total acute care bed allocation as determined by the methodology contained in paragraph (f) below, as well as any adjustments to the allocation as determined by the provisions of paragraphs (g) and (h) below. Such allocations shall also be consistent with the provisions of paragraph (i) and the requirements of Section 381.494(7)(b), Florida Statutes.

(f) Need Methodology. The need for new or additional acute care beds will be calculated using the uniform methodology described below based on age cohort population projections for each district, statewide service-specific discharge rates, statewide service-specific lengths of stay, statewide service-specific occupancy standards and patient flow adjustments. The elements of this methodology were developed by the Florida Task Force on Institutional Needs (TFIN). The age cohort discharge rates and average lengths of stay are based upon a statewide hospital utilization study conducted by the State Health Planning Agency. Periodic updating of the statewide discharge rates, average lengths of stay and patient flow factors will be done as data becomes available through the institution of statewide utilization reporting mechanisms. The methodology first calculates the need for specific age groups and services by multiplying the projected age cohort population times the statewide service-specific discharge rate and average length of stay standards to derive the number of patient days of care needed. These service-specific need projections are then summed to derive total patient days of care needed for persons under age 65 and persons age 65 and older. Next a district bed need projection is calculated by the application of service-specific occupancy standards for each service-specific patient day need for age cohorts under age 65. Prior to calculating district bed totals for the elderly cohort, that is, persons age 65 and over, a patient flow adjustment is applied which takes into account the statewide distribution of patient days of care to elderly non-residents and the net flow of elderly residents between service districts. After elderly patient days are thus adjusted, a combined occupancy standard for medical and surgical, intensive care and coronary care services is used to derive a bed need projection for persons age 65 and older. The service-specific bed need projections for under 65 age groups and the projected elderly bed need are summed to derive the district bed allocation.

1. Population projections. Population figures used in need calculation will be for age-specific cohorts residing in the relevant district projected five years into the future. Age-specific cohort projections of county population used shall be those developed by the State Health Planning Agency, and will be based on the latest mid-range projections published by the Bureau of Economic and Business Research of the University of Florida.

2. Population need by service. Population patient days of care needed by service for each district will be calculated through the application of the following formulas.

a. PDU = DMU + DIU + DCU + DO + DP

Where:

PDU = Projected total patient days of care needed by persons age 0 to 64 years;

DMU = Projected medical and surgical patient days needed by persons age 0 to 64 years obtained by multiplying the projected cohort population times the cohort-specific statewide medical and surgical discharge rate and average length of stay;

= PU x .099559 x 5.738;

PU = District projected population age 0 to 64 five years into the future;

DIU = Projected intensive care patient days needed by persons age 0 to 64 years obtained by multiplying the projected cohort population times the cohort-specific statewide intensive care discharge rate and average length of stay;

= PU x .006930 x 3.996;

DCU = Projected coronary care patient days needed by persons age 0 to 64 years obtained by multiplying the projected cohort population times the cohort-specific statewide coronary care discharge rate and average length of stay;

= PU x .003750 x 4.114;

DO = Projected obstetrical days of care obtained by multiplying the projected cohort population times the proportion of women statewide who give birth in hospitals, the average length of stay and the projected fertility rate;

= PF x .975 x 3.552 x FR/1000;

PF = The district projected population of females age 15 to 44 years five years into the future;

FR = The average fertility rate experienced in the district for the three most recent years based on resident live births as published in the Florida Vital Statistics;

= The projected number of births per 1,000 women age 15 to 44;

DP = Projected pediatric days of care needed by persons age 0 to 14 obtained by multiplying the projected cohort population times the cohort-specific statewide pediatric discharge rate and average length of stay;

= PP x .033979 x 4.393; and,

PP = The district projected population age 0 to 14 years five years into the future.

b. PDO = (DMO + DIO + DCO) x SRO

Where:

PDO = Projected total patient days of care needed by persons age 65 and older residing in the district;

DMO = Projected medical and surgical patient days needed by persons age 65 years and older obtained by multiplying the projected cohort population times the cohort-specific statewide medical and surgical discharge rate and average length of stay;

= PO x .317594 x 9.390;

PO = The district projected population age 65 years and older five years into the future;

DIO = Projected intensive care patient days needed by persons age 65 years and older obtained by multiplying the projected cohort population times the cohort-specific statewide intensive care discharge rate and average length of stay;

= PO x .036422 x 4.664;

DCO = Projected coronary care patient days needed by persons age 65 years and older obtained by multiplying the projected cohort population times the cohort-specific statewide coronary care discharge rate and average length of stay;

= PO x .029846 x 5.075; and,

SRO = .9731, the proportion of statewide acute care patient days provided to Florida residents age 65 and over.

3. District Bed Allocation. District bed allocations will be calculated through the application of the following formula.

a. DBA = MUA + IUA + CUA + PA + OA + EA

Where:

DBA = The district acute care bed allocation;

MUA = The district medical and surgical bed projection for persons age 0 to 64 years obtained by dividing the projected days of care needed by the product of the medical and surgical occupancy standard and the number of days in a year;

= DMU/(.80 x 365);

IUA = The district intensive care bed projection for persons age 0 to 64 years obtained by dividing the projected days of care needed by the product of the intensive care occupancy standard and the number of days in a year;

= DIU/(.80 x 365);

CUA = The district coronary care bed projection for persons age 0 to 64 years obtained by dividing the projected days of care needed by the product of the coronary care occupancy standard and the number of days in a year;

= DCU/(.75 x 365);

PA = The district pediatric care bed projection obtained by dividing the projected days of care needed by the product of the pediatric occupancy standard and the number of days in a year;

= DP/(.65 x 365);

OA = The district obstetrical care bed projection obtained by dividing the projected days of care needed by the product of the obstetrical occupancy standard and the number of days in a year;

= DO/(.75 x 365);

EA = The district acute care bed projection for persons age 65 and over obtained by dividing the patient flow-adjusted projected days of care needed by the product of the combined occupancy standard for medical and surgical, intensive care and coronary care services and the number of days in a year;

= (PDO + NFO)/(.797 x 365);

NFO = The district projected net flow of elderly patients;

= (OSP x DSOS) - DOUT + (SDOUT x DIN);

OSP = The sum of all patient days of care provided within Florida to non-resident elderly persons;

= (DMO + DIO + DCO) x .0269 for Districts 1 through 11;

DSOS = The district share of elderly patients from out of state;
= .0593 for District 1;
= -.0375 for District 2;
= .0354 for District 3;
= .1648 for District 4;
= .2159 for District 5;
= -.0253 for District 6;
= .0927 for District 7;
= .1861 for District 8;
= -.0289 for District 9;
= -.0081 for District 10; and,
= .3457 for District 11.

DOUT = The district projected outflow of patients to other districts;
= .0077 x (DMO + DIO + DCO) x .9731 for District 1;
= .0762 x (DMO + DIO + DCO) x .9731 for District 2;
= .1212 x (DMO + DIO + DCO) x .9731 for District 3;
= .0689 x (DMO + DIO + DCO) x .9731 for District 4;
= .0464 x (DMO + DIO + DCO) x .9731 for District 5;
= .0649 x (DMO + DIO + DCO) x .9731 for District 6;
= .0264 x (DMO + DIO + DCO) x .9731 for District 7;
= .0489 x (DMO + DIO + DCO) x .9731 for District 8;
= .0803 x (DMO + DIO + DCO) x .9731 for District 9;
= .1645 x (DMO + DIO + DCO) x .9731 for District 10; and,
= .0217 x (DMO + DIO + DCO) x .9731 for District 11.

SDOUT = The sum of district projected outflow of patients to other districts for Districts 1 through 11.

DIN = The district projected inflow of patients from other districts;
= .0197 for District 1;
= .0086 for District 2;
= .0643 for District 3;
= .0433 for District 4;
= .0445 for District 5;
= .1025 for District 6;
= .1267 for District 7;
= .0872 for District 8;
= .0705 for District 9;
= .0853 for District 10; and,

= .3475 for District 11.

(g) **District Bed Allocation Adjustment.** An adjustment to the district bed allocation computed in (f)3 above will be made when indicated, using the formula:

1. POR = ((PU + PO) x HUR)/(DBA x 365)

Where:

POR = Projected occupancy rate;

HUR = Historic use rate based upon total patient days of care delivered by acute care hospitals in the district for the three most recent annual hospital licensure reporting periods and district population estimates for that three year period; and,

DBA = The district bed allocation.

When POR is greater than .90 then DBA will be adjusted upward to the point at which:

2. ADBA = (PDU + PDO + NFO)/(.75 x 365)

Where:

ADBA = Adjusted district bed allocation.

When POR is less than .75 then DBA will be adjusted downward to the point at which:

3. ADBA = (PDU + PDO + NFO)/(.90 x 365).

(h) Peak Demand Considerations.

1. Required Capacity. Each district shall have sufficient bed capacity to meet service-specific peak demands. Each designated subdistrict shall be identified by the Local Health Council as experiencing either high or low seasonal peak demand. Subdistricts designated as high peak demand areas shall have sufficient total bed capacity to meet 99 percent of their peak demand. Subdistricts designated as low peak demand areas shall have sufficient total bed capacity to meet 95 percent of their peak demand.

2. Peak Demand Calculations. Peak demand calculations shall be performed using the following formula:

a. P = ADC + (Z x SRADC)

Where:

P = Peak bed demand to be estimated;

ADC = Average daily acute care patient census projected for the district or subdistrict of interest;

= (PDU + PDO + NFO)/365;

Z = Statistical value assigned to the district or subdistrict of interest, based on its peak demand capacity designation; and,

SRADC = Square root of ADC.

Each district and subdistrict designated as a high seasonal demand area and assigned a peak demand capacity of 99 percent will have a value of Z = 2.33. Each subdistrict designated as a low seasonal demand area and assigned a peak demand capacity of 95 percent will have a value of Z = 1.65.

3. Peak Demand Revisions to Bed Allocation. If the value of P computed for the district in (h)2. above is greater than the district bed allocation and the adjusted district bed allocation, then the district bed allocation will be revised to equal the value of P. Peak demand estimates for specific services and for beds within a subdistrict

shall be utilized by the Local Health Council in establishing its allocation of beds by type of service and by subdistrict.

(i) Geographic Accessibility Considerations.

1. Acute care hospital beds should be available and accessible within an automobile travel time of 30 minutes under average travel conditions to at least 90% of the population residing in an urban area subdistrict.

2. Acute care hospital beds should be available and accessible within a maximum automobile travel time of 45 minutes under average travel conditions to at least 90% of the population residing in a rural area subdistrict.

3. If the number of beds allocated to a subdistrict for a given service pursuant to paragraph (e) substantially exceeds the number of existing and approved beds in that subdistrict for such service and the conditions set forth in subparagraphs (i)1. or (i)2. are not satisfied, the Department shall consider the need for additional beds on a subdistrict basis in conjunction with the need for beds on the basis of the district as a whole and may approve such beds consistent with the provisions of paragraph (b).

DISTRICT IX HEALTH PLAN

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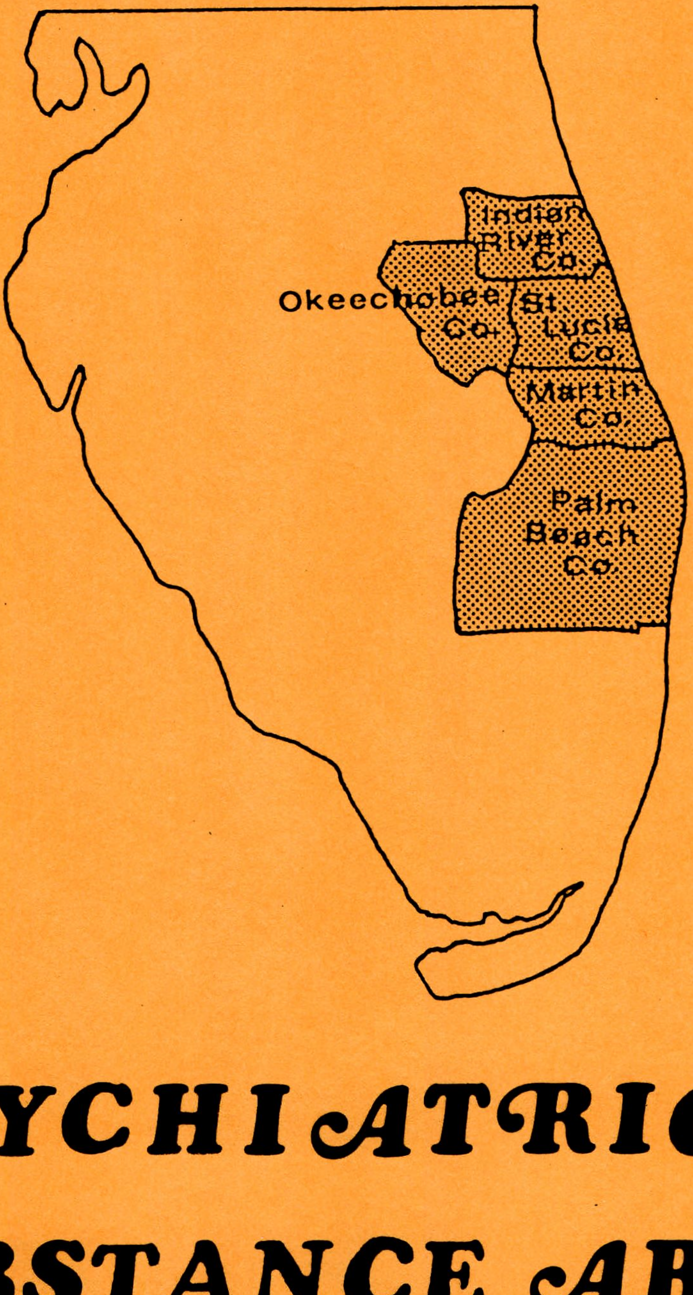

PSYCHIATRIC & SUBSTANCE ABUSE

PSYCHIATRIC AND SUBSTANCE ABUSE

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PSYCHIATRIC AND SUBSTANCE ABUSE

Introduction

The prevalence rates of mental illness and other mental health problems are not well documented. Generally accepted mental health status indicators include suicide rates, admissions to mental health institutions, service utilization data and epidemiologic field survey data. The U.S. Department of Health and Human Services defines mental health as "a relatively enduring state of being in which an individual is reasonably satisfying to self as reflected in his/her zest for living and feeling of self-realization. It also implies a large degree of adjustment to the social environment as indicated by the satisfaction derived from interpersonal relationships, as well as achievements".

An epidemiologic field survey was conducted by G. N. Warheit and Associates (Department of Psychiatry, University of Florida at Gainesville) between 1973 and 1976 in five Florida counties to measure depression, anxiety, psychosocial dysfunction, general psychopathology, and cognitive impairment in a population sample approximating Florida's population on race, age, sex, marital status and educational level. Based on the sample, Warheit and Associates established the following rates for a given population:

Normal	*60.3%*
Consultation/Education	*27.5%*
Outpatient	*9.8%*
Inpatient	*2.4%*

In District IX, the projected 1989 population is expected to be 1,162,180 of which 27,892 could require inpatient mental health services. This figure, however, should be used with great caution since the state of the art with respect to mental health epidemiology is rather underdeveloped.

Prevalence rates for alcoholism are based on social indicators such as alcohol related arrests, accidents, alcohol consumption, and incidence of cirrhosis of the liver. Drug abuse prevalence data is even more difficult to establish. Common indicators are death rates from overdose, emergency room data, drug-related arrests, and program utilization data.

The Commission on Accreditation of Hospitals defines substance abuse as "the use of any drug, chemical or substance in which the manner that the adverse, biological, psychological or social consequences of such use outweighs the benefits". Substances include alcohol, opium, cocaine, marijuana, methadone, other synthetic narcotics, other stimulants, depressants, and other halucinogens. The problem of alcohol and drug abuse is widespread throughout the United States, affecting individuals of every race, sex, age and socioeconomic status.

One social indicator technique developed by Parker Morden in 1974, estimated that 8.1% of District IX residents are problem drinkers. National statistics indicate that over 50% of all motor vehicle accident deaths are alcohol related.

Drug abuse is a major health problem that has received serious national attention in the recent past. One of the dominant concerns about the use of marijuana and other psychoactive drugs is the reduction in motivation and performance they may produce when used chronically, particularly by children and adolescents. Although the emphasis of drug abuse programs has been directed toward children and young adults, older adults and the elderly are also major drug abusers. Over-medication, particularly of older persons, with prescribed drugs, is responsible for a large portion of iatrogenic illness (ill health arising out of the medical care process, itself) requiring hospital care. Women are also greatly at risk in terms of iatrogenic illness. A study conducted in the early 1970's by Dr. Carl D. Chambers, former Director of Research for the New York State Narcotics Control Commission, found that an astonishing seventy percent of the habitual users were women. Almost half of American women (45%) used mood-altering drugs regularly in the early 1970's. There is great concern about the danger of prescribing tranquilizers that may mask a critical condition. An analysis of several leading medical journals in 1972 showed that the advertisements strongly tended to associate psychoactive drugs with female patients and nonpsychoactive drugs with male patients. It has been noted, however, that in the recent past, the numbers of prescriptions for valium have fallen but this situation still warrants close scrutiny by health professionals.

Current Capacity

Hospital inpatient psychiatric and substance abuse services are categorized into short term and long term services and whether they are located in general hospitals or free standing specialty hospitals. These definitions, access standards and utilization criteria can be found in the Department of Health and Rehabilitative Services Rule No. 10-5.11(25), (26), (27), which has been included here as Appendix A.

TABLE I

SHORT-TERM PSYCHIATRIC AND SUBSTANCE ABUSE INVENTORY
(AS OF MAY, 1984)

Specialty Hospital	Licensed Psychiatric Beds	Approved Psychiatric Beds	Licensed Substance Abuse Beds	Approved Substance Abuse Beds
Indian River Community Mental Health Center	15	35	0	20
Palm Beach County Comprehensive Community Mental Health Center	44	0	0	0
Lake Hospital of the Palm Beaches	56	0	16	0
Psychiatric Institute of Delray	0	70	0	17
Totals	**115**	**105**	**16**	**37**
General Hospital				
Humana Hospital Palm Beaches	0	80	0	0
Sebastian River Medical Center	0	0	16	0
Lawnwood Medical Center	0	60	0	0
JFK Health Institute	0	36	0	0
Totals	**0**	**176**	**16**	**0**
GRAND TOTAL	**115**	**281**	**32**	**37**

TABLE II

1983 ANNUAL LICENSED ADULT SHORT TERM PSYCHIATRIC OCCUPANCY STATISTICS

Facility	Beds		Patient Days	Licensed Bed Occupancy Rate	Number of Admissions	Average Length of Stay
	Licensed	Available				
Indian River Community Mental Health Center	15	15	5,180	94.6%	722	7.2
Palm Beach County Comprehensive Community Mental Health Center[1]	44	39[2]	7,880	58.9%	785	10.0
Lake Hospital of the Palm Beaches	32	35	11,018	94.3%	470	23.4

[1] Data reported for January - October, only.

[2] Adult Psychiatric Beds (24 Beds) and Geriatric Project (15 Beds)

Lake Hospital of the Palm Beaches is the only institution in 1983 that reported short term psychiatric beds for adolescents and short term substance abuse beds. Sebastian River Medical Center began reporting its substance abuse beds in March, 1984, after they were licensed as such.

TABLE III
LAKE HOSPITAL OF THE PALM BEACHES - 1983

Facility	Beds		Patient Days	Licensed Bed Occupancy Rate	Number of Admissions	Average Length of Stay
	Licensed	Available				
Adolescent Psychiatric*	24	14	3,253	49.3	21	154.9
Substance Abuse	16	16	3,437	58.8	148	23.2

*Began in April, 1983. By July, 1983, 18 beds were in operation and had reached 100% occupancy in available beds.

Long Term Psychiatric and Substance Abuse Inventory

There are, presently, no licensed long term psychiatric or long term substance abuse beds in District IX. The following beds have been approved within the last several months:

TABLE IV
APPROVED LONG TERM PSYCHIATRIC AND SUBSTANCE ABUSE BEDS
DISTRICT IX

Institution	Approved Psychiatric Beds	Approved Substance Abuse Beds
Glenbeigh of the Palm Beaches	0	60
Psychiatric Institute of Delray	15	0
Hospital Management Associates (Boca Raton)	60	0
Total	75	60

All of these beds are designated for the care of adolescents and will be located in Palm Beach County within specialty hospitals.

Bed Need

In order to plan for short term psychiatric and substance abuse inpatient beds, District IX has been divided into two subdistricts. The access standard of 45 minutes under average travel conditions for at least 90% of the service area's population for short term psychiatric services points to two subdistricts. One subdistrict is composed of Indian River County, Martin County, St. Lucie County and Okeechobee County and the other subdistrict is Palm Beach County.

The population estimates for these subdistricts projected for 1989 are:[1]

Subdistrict One (Four Northern Counties)	*345,080*
Subdistrict Two (Palm Beach County)	*817,100*

The District bed need for short term psychiatric beds is .35 beds/1000 population. In 1989, the psychiatric bed need will be:

Subdistrict One	*11*
Subdistrict Two	*0*

The bed need is further broken down by the type of hospital in which the beds will be located.

The District bed need for substance abuse beds is determined by applying the ratio of .06 beds/1000 population. Applying this ratio to Subdistrict One indicates that there will be no additional substance abuse beds needed by 1989 because the total need for Subdistrict One is 21 beds and there are presently 36 existing and approved beds. For Subdistrict Two, there will be a need for 16 additional beds. However, the District as a whole, would warrant only one additional bed.

These ratios do not apply to long term care services and the access time of two hours for long term care psychiatric services for 90% of the population would not allow for the division of the District into subdistricts.

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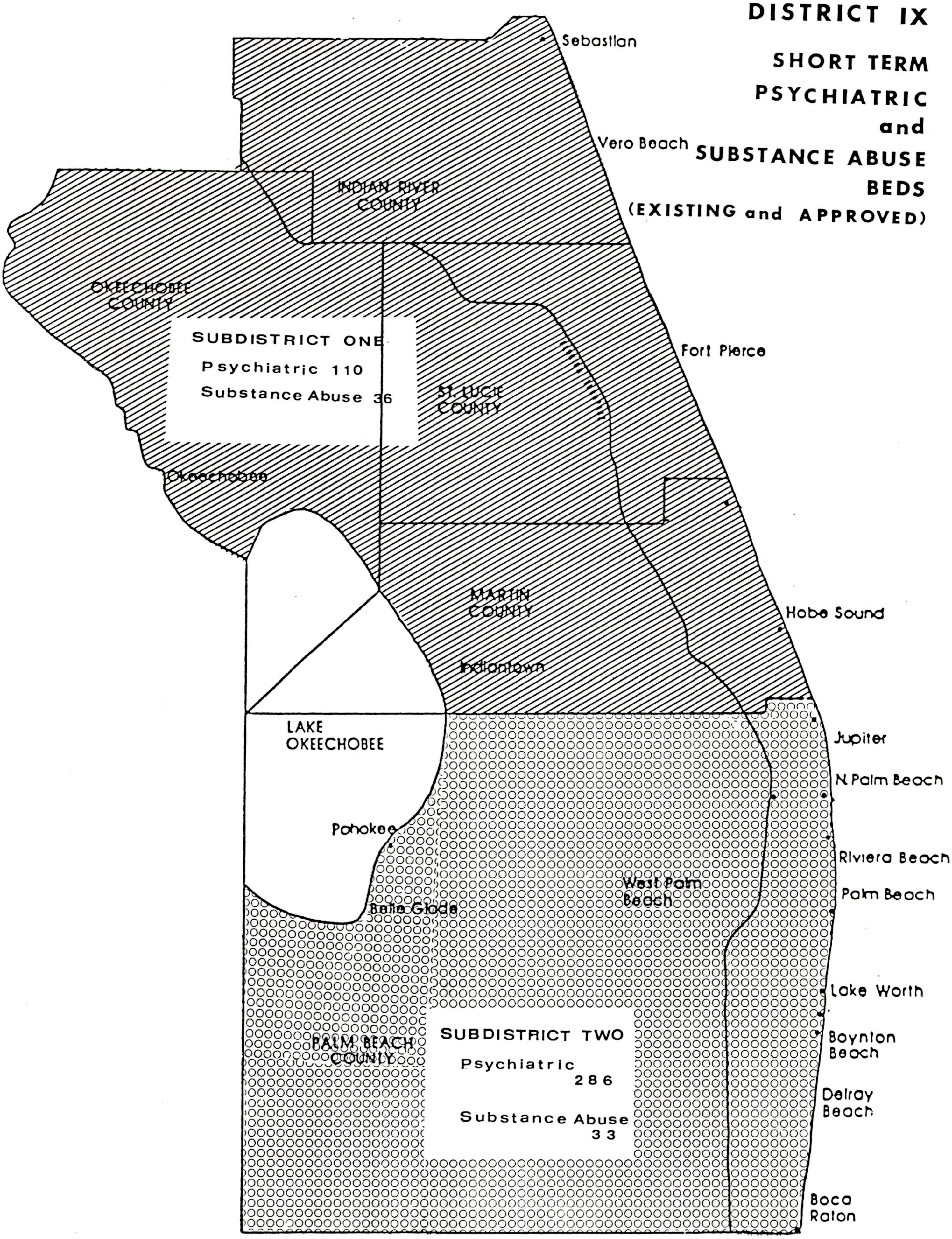
[1] *These are 1983 HRS projections for 1989 and are subject to change when DHS releases new 1989 projections on or about July 1, 1984.*

DISTRICT IX

SHORT TERM PSYCHIATRIC and SUBSTANCE ABUSE BEDS (EXISTING and APPROVED)



Priority Recommendations

In addition to the Psychiatric and Substance Abuse Methodology (Rule No. 10-5.11-(25)(26),(27), the District IX Health Council has established the following recommendations which should be used concurrently in planning psychiatric and substance abuse hospital bed need and allocation.

I. A. *The following subdistricts are identified for the purpose of allocating short term psychiatric and substance abuse beds:*

- **a. *Subdistrict One (Indian River, Martin, St. Lucie, and Okeechobee Counties).***
- **b. *Subdistrict Two (Palm Beach County)***

B. *Glades Area: New applications in the Glades area should not be considered as competing applications with the Palm Beach County Subdistrict. Consideration should be given to patient flow patterns from neighboring Hendry County into the Glades Area.*

RATIONALE: The short term psychiatric access standard states that these services should be available to at least 90% of the service area's population within 45 minutes driving time under average travel conditions. This access standard warranted the breakup of District IX into two subdistricts. However, the Glades Area situation is unique in the District. The Glades Area is defined as that portion of western Palm Beach County comprising population zone 099001. Currently, this area is included with the subdistrict of Palm Beach County. However, it would not be practical nor fair to compare the very rural Glades region with the highly developed urban coastal regions. The poor east-west highways and basic lack of transporation prohibit residents of the Glades area from utilizing services on the coast. Hence, their special needs should be addressed separately and distinctly from the rest of Palm Beach County. Furthermore, because Hendry County and western Palm Beach County are adjacent and are both very rural and somewhat isolated from the coastal areas, their needs should be considered concurrently. Many residents in both Hendry and the Glades visit the other for a variety of services including health care.

II. *The methodologies in Rule No. 10-5.11 (25), (26), (27) should be utilized on a subdistrict basis for short term psychiatric and substance abuse hospital inpatient services.*

RATIONALE: Without more concrete data on the criteria that determine the need for such services, the District IX Health Council will utilize the present HRS methodology.

III. *In regard to long term care psychiatric and substance abuse services, District IX will not be broken up into subdistricts for planning purposes.*

RATIONALE: The access standard for long term psychiatric services of two hours driving time for 90% of the population should be satisfied without the division of District IX into subdistricts.

IV. ***Priority shall be given to those applicants who demonstrate that they will conform to the goals established by Mental Health Board No. 9, Inc. or another appropriate entity in their most recent District Plan.***

RATIONALE: *Coordination between District IX Health Council, Inc. and Mental Health Board No. 9, Inc. is essential in order to plan properly for an appropriate mix of psychiatric and substance abuse services.*

V. ***In preparation for revising the Psychiatric/Substance Abuse Section of the Acute Care Hospital Plan for 1985, the District IX Health Council should continue to initiate activities which address the following:***

a. ***An improved data and information base***
b. ***Development of criteria for the allocation of needed psychiatric/substance abuse beds***
c. ***Determine the mix of psychiatric and substance abuse services that is necessary for District IX.***

RATIONALE: *Based on limited information available to the Council, it is felt that a great deal of study is needed prior to the Council's making detailed recommendations regarding Psychiatric/Substance Abuse services for this District.*

PSYCHIATRIC
EFFECTIVE 4/7/83

RULES OF
STATE OF FLORIDA
DEPARTMENT OF HEALTH AND REHABILITATIVE SERVICES
CHAPTER 10-5, FLORIDA ADMINISTRATIVE CODE
PROCEDURES FOR THE ADMINISTRATION OF SECTIONS 381.493-381.499, FLORIDA STATUTES, HEALTH FACILITIES AND HEALTH SERVICES PLANNING ACT
"CRITERIA AND STANDARDS FOR SHORT TERM AND LONG TERM HOSPITAL PSYCHIATRIC AND SUBSTANCE ABUSE INPATIENT SERVICES"

(25) Short Term Hospital Inpatient Psychiatric Services.

(a) Short term hospital inpatient psychiatric services means a category of services which provides a 24-hour a day therapeutic milieu for persons suffering from mental health problems which are so severe and acute that they need intensive, full-time care. Acute psychiatric inpatient care is defined as a service not exceeding three months and averaging a length of stay of 30 days or less for adults and a stay of 60 days or less for children and adolescents under 18 years.

(b) Short term hospital inpatient psychiatric services may be provided in specifically designated beds in a hospital holding a general license, or in a facility holding a specialty hospital license.

(c) Applications for proposed short term hospital inpatient psychiatric services will be reviewed according to relevant statutory and rule criteria. A favorable need determination for proposed general acute care psychiatric inpatient services will not normally be given to an applicant unless a bed need exists according to paragraph (25)(d) of this rule. A favorable Certificate of Need determination may be made when the criteria, other than as specified in 25(d), as provided for in 381.494(6)(c), Florida Statutes, and paragraph (25)(e) of this rule, demonstrate need.

(d) Bed allocations for acute care short term general psychiatric services shall be based on the following standards:

1. A minimum of .15 beds per 1,000 population should be located in hospitals holding a general license to ensure access to needed services for persons with multiple health problems. These beds shall be designated as short term inpatient hospital psychiatric beds.

2. .20 short term inpatient hospital beds per 1,000 population may be located in specialty hospitals, or hospitals holding a general license. The distribution of these beds shall be based on local need, cost effectiveness, and quality of care considerations.

3. The short term inpatient psychiatric bed need for a Department service district five years into the future shall be calculated by subtracting the number of existing and approved beds from the number of beds calculated for year_x, based on a bed need ratio of .35 beds per 1,000 population projected for year_x and based on latest mid-range projections published by the Bureau of Economic and Business Research at the University of Florida. These beds are allocated in addition to the total number of

general acute care hospital beds allocated to each Department District established in Rule 10-5.11(23).

4. Occupancy Standards. New facilities must be able to project an average 70% occupancy rate for adult psychiatric beds and 60% for children and adolescent beds in the second year of operation, and must be able to project an average 80% occupancy rate for adult beds and 70% for children and adolescent short term psychiatric inpatient hospital beds for the third year of operation.

5. No additional short term inpatient hospital adult psychiatric beds shall normally be approved unless the average annual occupancy rate for all existing adult short term inpatient psychiatric beds in a service district is at or exceeds 75% for the preceding 12 month period. No additional beds for adolescents and children under 18 years of age shall normally be approved unless the average annual occupancy rate for all existing adolescent and children short term hospital inpatient psychiatric beds in the Department district is at or exceeds 70% for the preceding 12 month period.

6. Hospitals seeking additional short term inpatient psychiatric beds must show evidence that the occupancy standard defined in paragraph six is met and that the number of designated short term psychiatric beds have had an occupancy rate of 75% or greater for the preceding year.

7. Unit size. In order to assure specialized staff and services at a reasonable cost, short term inpatient psychiatric hospital based services should have at least 15 designated beds. Applicants proposing to build a new but separate psychiatric acute care facility and intending to apply for a specialty hospital license should have a minimum of 50 beds.

(e) Other standards and criteria to be considered in determining approval of a Certificate of Need application for short term hospital inpatient psychiatric beds are as follows:

1. Applicants shall show evidence that the type of service and the number of proposed beds are consistent with the needs in the community stated in the Local Health Council plans, local Mental Health District Board plans, State Mental Health Plan, and local needs assessment data.

2. Applicants shall indicate in their application for new or expanded short term hospital inpatient psychiatric services:

a. Expected source of referral

b. Service area

c. Expected average length of stay

d. The relationship of the proposed services to other components of the community mental health system within the proposed service area.

3. In order for the Department to ensure that short term hospital inpatient psychiatric service needs of all segments of the population in a given service area are adequately met, the applicant shall indicate the percentage of patient days allocated to:

a. Indigent clients

b. Medicaid clients

c. Baker Act funded clients
d. Private pay patients
e. Other.

4. Applicants shall indicate the availability of other inpatient psychiatric services in the proposed service area, including the number of beds available in crisis stabilization units, short term residential treatment programs, and other inpatient beds whether licensed as a hospital facility or not.

5. Hospital based psychiatric services must provide outpatient services or must be formally linked with community outpatient programs, such as local psychiatrists, local psychologists, community mental health programs, or other local psychiatric outpatient programs.

6. Development of new short term hospital inpatient psychiatric beds shall be through conversion of underutilized beds in other hospital services, unless conversion costs are prohibitive when compared with development of new facilities, or other factors to be specified by the applicant prohibit such conversion.

7. Access standard. Short term inpatient hospital psychiatric services should be available within a maximum travel time of 45 minutes under average travel conditions for at least 90% of the service area's population.

(26) Long Term Psychiatric Services.

(a) Long term psychiatric services means a category of services which provides hospital based inpatient services averaging a length of stay of 90 days.

(b) Long term inpatient hospital psychiatric services may be provided in specifically designated beds in a hospital holding a general license, or in a facility holding a specialty hospital license.

(c) Applications for proposed long term inpatient hospital psychiatric beds will be reviewed according to relevant statutory and rule criteria. A favorable need determination for long term hospital inpatient psychiatric beds will not normally be given to an applicant unless the following criteria and standards are met:

1. No additional long term psychiatric beds shall be added in a Department service district unless the average annual occupancy rate for all existing long term hospital psychiatric beds in a Department district is at or exceeds 80% for the preceding year.

2. An applicant proposing additional long term psychiatric hospital inpatient services must be able to project an annual average occupancy rate of 80% for the third year of operation.

3. Access Standard. Long term hospital inpatient psychiatric services should be available within a maximum travel time of 2 hours under average travel conditions for at least 90% of the service area's population.

4. Applicants for long term hospital inpatient psychiatric services shall show evidence that the type of service and the number of proposed beds is consistent with the needs in the community as perceived by the local health council, the

Mental Health District Board, the State Mental Health Plan, and other available needs assessment data.

(d) Applicants applying for long term hospital inpatient psychiatric beds shall identify:

1. The target population to be served
2. Service area
3. Expected source of referrals
4. Expected average length of stay
5. The relationship of the proposed services to other components of the community mental health system within the defined service area.

(e) In order for the Department to assure that the long term psychiatric hospital inpatient needs of all clients in a given service area are adequately met, the applicant shall indicate the percentage of patient days allocated to:

1. Indigent clients
2. Medicaid clients
3. Private pay patients
4. Other.

(27) Short Term and Long Term Hospital Inpatient Substance Abuse Services.

(a) Hospital inpatient substance abuse services means a category of hospital based services which provides a 24-hour a day therapeutic environment for persons suffering from the effects of substance abuse.

(b) Short term hospital substance abuse inpatient services are defined as short-term services not exceeding an average length of stay of 28 days.

(c) Long term hospital substance abuse inpatient services are defined as services exceeding an average length of stay of 28 days.

(d) Service location. Hospital inpatient substance abuse services may be provided in specifically designated beds in hospitals holding a general license, or in a facility holding a specialty hospital license.

(e) Applications for proposed additional or new hospital inpatient substance abuse beds will be reviewed according to relevant statutory and rule criteria. A favorable need determination for proposed short term and long term hospital inpatient substance abuse beds will not normally be given to an applicant unless a bed need exists according to paragraph (27)(f) of this rule. A favorable Certificate of Need determination may be made when the criteria, other than specified in (27)(f), as provided for in 381.494(6)(c), Florida Statutes, and paragraph (27)(h) of this rule, demonstrate need.

(f) Bed allocations for short term and long term hospital substance abuse inpatient services shall be based on the following standards:

1. The bed need for short term hospital inpatient substance abuse for a Department service district five years into the future shall be calculated by subtracting the number of existing and approved beds from the number of beds calculated for year_x, based on a bed need ratio of .06 beds per 1,000 population projected for year_x and based on latest mid-range projections

published by the Bureau of Economic and Business Research at the University of Florida. These beds are allocated in addition to the total number of general acute care hospital beds allocated to each Department district established in Rule 10-5.11(23).

2. A favorable need determination for long term hospital inpatient substance abuse beds will not normally be given to an applicant unless the applicant shows evidence that the type of service and the number of proposed beds are consistent with the needs in the community as stated in the Local Health Council plans, the Mental Health District Board plans and other available needs assessment data.

(g) Beds designated for detoxification services in hospitals holding a general license shall be considered a subset of the total number of medical surgical acute beds allocated to each district under Rule 10-5.11(23). Beds designated for detoxification services in facilities holding a specialty hospital license shall be considered a subset of the number of beds allocated to each district under (27)(f) of this rule.

(h) Other standards to be considered in evaluating a Certificate of Need application for hospital inpatient substance abuse services are as follows:

1. No additional or new hospital inpatient substance abuse beds shall normally be approved in a Department service district unless the average occupancy rate for all existing hospital based substance abuse inpatient beds is at or exceeds 80% for the preceding 12 month period.

2. Hospitals seeking additional beds must demonstrate that beds designated for inpatient substance abuse services have had an annual average occupancy rate of greater than 80% for the preceding 12 month period.

3. Applicants for short term hospital substance abuse beds shall show evidence that the type of service and the number of proposed beds are consistent with the needs in the community, stated in the Local Health Council plans, local Mental Health District Board plans, the State Mental Health Plan, and other available needs assessment data.

4. Unit size. A proposal for new hospital inpatient substance abuse beds should have a minimum unit size of ten designated beds.

5. Hospitals applying for new or expanded hospital inpatient substance abuse services must identify in their application:

a. Expected source of referrals
b. Expected average length of stay
c. Service area
d. Target population to be served

6. Hospital inpatient substance abuse services should be provided in a clearly identifiable unit within a hospital and must have staff trained in substance abuse treatment.

7. Continuity. All hospital based substance abuse treatment programs must be formally linked with outpatient treatment programs.

8. In the establishment of new substance abuse services, preference shall be given to the development of new beds through conversion of underutilized beds in other services, unless conversion costs are prohibitive when compared with

development of new services, or other factors to be specified by the applicant prohibit such conversion.

9. In order for the Department to assure that the acute inpatient hospital substance abuse service needs of all clients in a given service area are adequately met, the applicant shall indicate the percentage of patient days allocated to:

a. Indigent clients
b. Medicaid clients
c. Private pay patients
d. Other.

10. Occupancy Standards. New substance abuse programs must be able to project an average 70 percent occupancy rate in the second year of operation and must be able to project an average 80 percent occupancy rate by the third year of operation.

Specific Authority: 381.031(1)(g)11, F.S.
381.493(2), F.S.
381.494(5), (7), (8), F.S.
Law Implemented: 381.494(7), (8), F.S.
History: New

APPENDIX B

INVENTORY OF PUBLIC AND PRIVATE MENTAL HEALTH AND SUBSTANCE ABUSE RESOURCES

INVENTORY OF PUBLIC AND PRIVATE MENTAL HEALTH AND SUBSTANCE ABUSE RESOURCES

SUBDISTRICT ONE

MENTAL HEALTH

Name and Address of Agency/Person	Public/Private	Service Provided
Catholic Social Services 2001 Building 2001 Ninth Avenue Suite 210E Vero Beach, Florida 32960	Private	Adoption services, counseling for unwed parents & unplanned pregnancy, counseling for individuals, couples and families.
Children's Protective Services 1505 Delaware Avenue Fort Pierce, Florida 33450	Public	Foster care, care of abused neglected children, counseling
Council on Aging St. Lucie County 127 Arcade Building Fort Pierce, Florida 33450	Public	Referral, transportation, recreational.
Crisis Line Mental Health Association P.O. Box 427 Vero Beach, Florida 32960	Private	Information and Referral
Helping Hand Neighbors 809 North Ninth Street Fort Pierce, Florida 33450	Private	Recreation, counseling, congregate feeding program.
Indian River Community Mental Health Center, Inc. 800 Avenue H Fort Pierce, Florida 33450		
Satellite Clinics		
Indian River County 1031 18 Street - Suite 1 Vero Beach, Florida		
Martin County 517 East Oseola Street Stuart, Florida 33494		
Okeechobee County Okeechobee, Florida 33472		

INVENTORY OF PUBLIC AND PRIVATE MENTAL HEALTH AND SUBSTANCE ABUSE RESOURCES

SUBDISTRICT ONE

MENTAL HEALTH

Name and Address of Agency/Person	Public/Private	Service Provided
Indian River County Council on Aging 955 Seventh Avenue Vero Beach, Florida 32960	Public	Transporation service information & referral, homemaker service.
Martin County Council on Aging 925 Lincoln Avenue Stuart, Florida 33494	Public	Transporation, homemaking service
Mental Health Association 955 Seventh AVenue Vero Beach, Florida 32960	Private	Educational programs
Real Life Children's Ranch 585 South U.S. 441 Okeechobee, Florida 33472	Private	Total care for dependent & neglected children (boys & girls)
Shiloh Youth Ranch Roseland Road Vero Beach, Florida 32960	Private	Home for needy boys
Spouse Abuse of Indian River P.O. Box 427 Vero beach, Florida 32960	Private	Temporary shelter for abused women (or men), counseling, referral
Tri-County Rehabilitation Center 4461 Southeast Federal Highway Stuart, Florida 33494	Private	Personal adjustment service to help clients find employment, skills training.
Youth Services, HRS 1235 Sixteenth Street Vero Beach, Florida 32960	Public	Children's protective serivces, foster home care probation.

INVENTORY OF PUBLIC AND PRIVATE
MENTAL HEALTH AND SUBSTANCE ABUSE RESOURCES

SUBDISTRICT ONE

SUBSTANCE ABUSE

Name and Address of Agency/Person	Public/Private	Service Provided
Al-Anon 203 West Oseola Avenue Stuart, Florida 33494	Private	Voluntary self-help programs, individual & group counseling
Alco-Hope 5923 37 Street Vero Beach, Florida 32960	Private	Residential rehabilitation program
Alcoholics Anonymous 204 South Lucie Avenue Stuart, Florida 33494	Private	Voluntary self-help programs, individual & group counseling.
Driving While Intoxicated Counter Measure Project 3222 Center, S. - U.S. Hy. #1 P.O. Box 3837 Fort Pierce, Florida 33450	Public	Educational therapy.
Newport Club 845 Seventh Avenue Vero Beach, Florida 32960	Private	Crisis line information & referral for alcoholics & their families
Alcoholics Anonymous Indian River Intergroup 955 Seventh Avenue - Room 12 Vero Beach, Florida 32960	Private	Voluntary self-help programs, individual & group counseling.

INVENTORY OF PUBLIC AND PRIVATE MENTAL HEALTH AND SUBSTANCE ABUSE RESOURCES

SUBDISTRICT TWO

MENTAL HEALTH

Name and Address of Agency/Person	Public/Private	Service Provided
Catholic Service Bureau 900 54 Street P.O. Box 8246 West Palm Beach, Florida 33407(2)	Private	Marriage, individual, parent/child counseling
Center for Family Services, Inc. 208 Clematis Street - Room 403 West Palm Beach, Florida 33401	Private	Family counseling
Domestic Assault Project 307 North Dixie Highway West Palm Beach, Florida 33401	Private	Crisis counseling to victims of domestic assault, referral
Emotions Anonymous 717 Prosperity Farms Road North Palm Beach, Florida 33408	Private	Mutual support group
Jewish Family & Children's Service of Palm Beach County 2411 Okeechobee Boulevard West Palm Beach, Florida 33409	Private	Counseling--marital, family, individual, divorced and elderly
Marital Stress & Divorce Center 328 Fourth Street West Palm Beach, Florida 33401	Private	Counseling--mariage, family and past divorced. Individual therapy, adolescent & children therapy
Palm Beach County Comprehensive Community Mental Health Center, Inc. 1041 45 Street West Palm Beach, Florida 33407	Public	Emergency services, inpatient, gerontology services, residential services for chronically mentally disabled, short term crisis support services, rape counseling, Vietnam veterans counseling.
Palm Beach County Division of Senior Services Executive Plaza 301 Broadway - Suite #201 Riviera Beach, Florida 33404	Public	Counseling, education, outreach, recreation, transportation
Parent/Child Study Center of the Palm Beaches 3802-4 East Avenue West Palm Beach, Florida 33407	Public	Diagnostic evaluation, counseling, parent training, therapeutic foster homes, emergency services, sexual assault counseling.

INVENTORY OF PUBLIC AND PRIVATE MENTAL HEALTH AND SUBSTANCE ABUSE RESOURCES

SUBDISTRICT TWO

MENTAL HEALTH

Name and Adddress of Agency/Person	Public/Private	Service Provided
Parents in Need, Inc. 2305 South Flagler Drive West Palm Beach, Florida 33401	Private	Therapy groups for parents who abuse their children, counseling, outreach.
Sabal Palm Youth Service Center 4208 Australian Avenue West Palm Beach, Florida 33407	Private	Residential care program for children ages 10 - 16.
Veterans Administration Outpatient Clinic 301 Broadway Riveria Beach, Florida 33404	Public	Counseling to all eligible veterans
Women's Horizons 901 South Olive Avenue West Palm Beach, Florida 33401	Private	Counseling for Women.
Center for Family Services, Inc. 208 Clematis Street - Room 403 West Palm Beach, Florida 33401	Private	Family counseling
Domestic Assault Project 307 North Dixie Highway West Palm Beach, Florida 33401	Private	Crisis counseling to victims of comestic assault, referral
Emotions Anonymous 717 Prosperity Farms Road North Palm Beach, Florida 33408	Private	Mutual support group
Jewish Family & Children's Service of Palm Beach County 2411 Okeechobee Boulevard West Palm Beach, Florida 33409	Private	Counseling--marital, family, individual, divorced and elderly
Marital Stress & Divorce Center 328 Fourth Street West Palm Beach, Florida 33401	Private	Counseling--mariage, family and past divorced. Individual therapy, adolescent & children therapy
Palm Beach County Comprehensive Community Mental Health Center, Inc. 1041 45 Street West Palm Beach, Florida 33407	Public	Emergency services, inpatient, gerontology services, residential services for chronically mentally disabled, short term crisis support services, rape counseling, Vietnam veterans counseling.

INVENTORY OF PUBLIC AND PRIVATE MENTAL HEALTH AND SUBSTANCE ABUSE RESOURCES

SUBDISTRICT TWO

MENTAL HEALTH

Name and Address of Agency/Person	Public/Private	Service Provided
Palm Beach County Division of Senior Services Executive Plaza 301 Broadway - Suite #201 Riviera Beach, Florida 33404	Public	Counseling, education, outreach, recreation, transportation
Parent/Child Study Center of the Palm Beaches 3802-4 East Avenue West Palm Beach, Florida 33407	Public	Diagnostic evaluation, counseling, parent training, therapeutic foster homes, emergency services, sexual assault counseling.
Parents in Need, Inc. 2305 South Flagler Drive West Palm Beach, Florida 33401	Private	Therapy groups for parents who abuse their children, counseling, outreach.
Sabal Palm Youth Service Center 4208 Australian Avenue West Palm Beach, Florida 33407	Private	Residential care program for children ages 10 - 16.
Veterans Administration Outpatient Clinic 301 Broadway Riveria Beach, Florida 33404	Public	Counseling to all eligible veterans
Women's Horizons 901 South Olive Avenue West Palm Beach, Florida 33401	Private	Counseling for Women.
Center for Family Services, Inc. 500 East Spanish River Boulevard Boca Raton, Florida 33432	Private	Family Counseling
Center for Group Counseling 166 East Boca Raton Road BocaRaton,Florida 33432	Public	Group counseling
Crisi Line Information & Referral Service Executive Arcade Building 1301 Lake Avenue Lake Worth, Florida 33460	Public	Crisis services
The Haven, Inc. 430 Northeast Fifth Avenue P.O. Box 387 Delray Beach, Florida 33444	Private	Therapeutic residence for dependent, neglected boys age 8 - 14.

INVENTORY OF PUBLIC AND PRIVATE MENTAL HEALTH AND SUBSTANCE ABUSE RESOURCES

SUBDISTRICT TWO

MENTAL HEALTH

Name and Address of Agency/Person	Public/Private	Service Provided
Lake Hospital of the Palm Beaches 1710 Fourth Avenue North Lake Worth, Florida 33460	Private	Psychiatric inpatient
Palm Beach Junior College Women's Center 4200 Congress Avenue Lake Worth, Florida 33461	Public	Counseling for women
South County Mental Health Center, Inc. 16155 South Military Trail P.O. Drawer 3005 Delray Beach, Florida 33444	Public	Emergency services, residential services for chronically mentally ill, therapeutic foster care, case management, adolescent group home.
South Palm Beach Count Migrant Coordinating Council Route #1 P.O. Box N Delray Beach, Florida 33444	Public	Counseling, outreach, referral, translation, transportation.
Western Palm Beach County Mental Health Clinic, Inc. 417 North West 16 Street - #1 Belle Glade, Florida 33430	Public	Crisis services, adult outpatient, special childrens services, evaluations, individual, group, family therapy, migrant health program, day treatment for the chronically ill.

INVENTORY OF PUBLIC AND PRIVATE MENTAL HEALTH AND SUBSTANCE ABUSE RESOURCES

SUBDISTRICT TWO

SUBSTANCE ABUSE

Name and Address of Agency/Person	Public/Private	Service Provided
Al-Anon Family Group P.O. Box 1229 West Palm Beach, Florida 33402	Private	Educational therapy, support for families of problem drinkers.
Alcoholics Anonymous 301 Broadway - Suite #122 Riviera Beach, Florida 33404	Private	Voluntary self-help program, individual group counseling.
Comprehensive Alcohol Rehabilitation Program, Inc. P.o. Box 2507 West Palm Beach, Florida 33402	Public	Residential and outpatient services.
Drug Abuse Treatment Association, Inc. 301 Broadway - Suite #140 Riviera Beach, Florida 33404	Public	Outpatient therapy and residential services.
Gratitude Guild, Inc. 317 North Lakeside Court West Palm Beach, Florida 33407	Public	Residential services for women.
Palm Beach Institute 1101 South Olive Avenue West Palm Beach, Florida 33401	Private	Residential alcohol treatment.
Palm Beach Faith Farm, Inc. 9538 Highway 441 Boynton Beach, Florida 33436	Private	Residential counseling services for males.
Center for New Directions 2300 Seacrest Boulevard Delray Beach, Florida 33444	Public	Outpatient drug services, residential drug treatment.
South County Mental Health Center, Inc. 16155 South Military Trail P.O. Drawer 3005 Delray Beach, Florida 33444		
Alcohol Services		
The Shelter 265 North East Fifth Avenue Delray Beach, Florida 33444	Public	Short term residential care for those abusing alcohol.

INVENTORY OF PUBLIC AND PRIVATE MENTAL HEALTH AND SUBSTANCE ABUSE RESOURCES

SUBDISTRICT TWO

SUBSTANCE ABUSE

Name and Address of Agency/Person	Public/Private	Service Provided
Palm Trail Lodge 914 North Palm Trail Delray Beach, Florida 33444	Public	Halfway house, extended residential care for alcoholics.
Crisis Unit 343 North East Fifth Avenue Delray Beach, Florida 33444	Public	Detoxification
Alcoholics Anonymous Belle Glade, Florida 33430	Private	Voluntary self-help program, individual group counseling.
Comprehensive Alcoholism Rehabilitation Programs, Inc. 417 North West 16 Street - #1 Belle Glade, Florida 33430	Public	Outpatient, residential services prevention program, alcohol detoxification.